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SERVICES FOR CHILDREN

WITH SIGNIFICANT DEVELOPMENTAL DISABILITIES OR BEHAVIOUR DISORDERS

IN NEW BRUNSWICK

the Applied Research Consulting House ltd.

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2021 Cliff Road / Mississauga, Ontario L5A 3N7 / (416) 273-4098

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December, 1983

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December 28, 1983

The Honourable Nancy Clark Teed
Minister of Social Services
Province of New Brunswick

Madame:

I am pleased to present you with this Report based on our study of services for children with developmental disabilities or behavioural disorders in the province of New Brunswick. The findings reflect the efforts of a team of professionals. The co-operation of personnel at all levels of your Department in helping to facilitate our study is gratefully acknowledged. To the best of our ability, we have tried to present the nature of existing services with both factual accuracy and sensitivity. As the individual responsible for preparation of the report, I take full responsibility for the interpretation of these facts and the nature of recommendations presented.

May I say that the team as a whole, and I individually, found this exercise personally gratifying as well as challenging. To discern how children with severe disabilities may be served best is one of those tasks which deserves our every attention.

Yours sincerely,

Aldred H. Neufeldt, Ph.D.
Principal

AHN/jr
encl

SERVICES FOR CHILDREN WITH SIGNIFICANT DEVELOPMENTAL DISABILITIES OR BEHAVIOUR DISORDERS IN NEW BRUNSWICK

EXECUTIVE SUMMARY

This Report presents the findings and recommendations of a study of services for children with severe developmental disabilities and/or behaviour disorders. Commissioned by New Brunswick's Department of Social Services, the study gave particular attention to the Dr. William F. Roberts Hospital School (WFR) but also examined other resources available throughout the province. In the course of study, team members interviewed a cross-section of relevant personnel within government as well as a sample of concerned people outside: reviewed a wide variety of documents including correspondence, planning documents etc.: sampled client files and program material: and, spent a considerable amount of time observing existing program and administrative practices.

As of September, the WFR was providing care for three groups of children: a small number (17) with multiple handicaps and profound retardation; a second small group (16) that was severely retarded and had some related disabilities: and, a substantial group who were called "behaviourally disordered". While some of this latter group had a history of considerable disruptive behaviour. many of the behaviour problems appeared to us relatively modest and situational in nature which could have been handled in normal community service contexts given some specialized support services. Of the 131 children admitted to the WFR in 1982, 50% came for respite care. Only 8 of the children admitted spoke French as their mother tongue. More detailed examination of data shows that the WFR essentially serves these people closest to it, with the largest user being the Saint John region. The francophone communities remain virtually unserved.

In the WFR program itself we saw many instances of sensitive and appropriate actions by staff with obvious good intentions. However, this took place in a context of considerable fragmentation and disorganization.

- o No evident individualized child-centred programs (IPPs) had been planned for, or developed. Sound behavioural baselines from which programs might be planned were usually non-existent.

- o Each discipline (e g. teachers. psychologists. social workers therapists. residential counsellors, etc) essentially was working independently of others. with little evidence of joint program planning between them.

- o Documentation of both program and administrative activities was inadequate and frequently fragmented (there is, for example. no single master file on a child which contains all relevant information pertinent to programming requirements).

- o There was no consistent, clearly defined, vision in place as to how children with multiple needs ought to be served.

- o Communication problems of many kinds have existed both within the WFR, and between the WFR and other entities, leaving the facility inward-looking and isolated.

The net result of the foregoing and other factors is that the WFR progam reflects primarily a "custodial-residential care" model of operation.

The Departments of Social Services, Education and Health have fostered a variety of community-based services for like children over the past number of years. Although it was not possible to determine the exact number, it is evident that a sizeable number of children similar to those currently in the WFR exist in the community. However, community services also have some short-comings, including:

- o An absence of some essential community-based services such as expert travelling assessment/diagnostic teams; inter-disciplinary resource personnel; regionally based behaviour/ training centres; etc.

- o A dearth of support to natural parents, foster parents, etc., in the form of homemakers and respite services, better and more accessible information on resources available to help cope with difficult-to-serve children.

- o Lack of coordination between Departments, Schools and Agencies when planning for how best to serve those children.

- o Children's needs are too often left unattended until they have accumulated to the point where drastic action is required, as a result of which services are crisis response rather than program oriented.

Overall, there is an absence of clear vision and leadership on how children with developmental disabilities and/or behavioural disorders ought to be served. The Department of Social Services seems to have the lead respc sibility, but this has not been clearly communicated to

regional personnel, nor has it been clearly translated into program/ budget terms. At the same time, the Department has an excellent basis for action through its Child and Family Services and Family Relations Act. There is a need though to translate provisions of this Act into "Statements of First Principles", Mission Statements and Work Plans. With these factors in mind, we recommend that:

> Recommendation 1: the Department of Social Services be clearly designated as lead Department responsible for developing community services for children with disabilities, and that the Department adopt statements of first principle such as those outlined in the Report, translating such principles into a mission statement and work plans whereby such children may be well served in their natural environments.
>
> Recommendation 2: the Department vigorously pursue development of a comprehensive array of services including child-centred individual programming, case management and inter-disciplinary team approaches.

We found that existing resources in the community and the WFR had not been used to the extent possible. The WFR budget represents 79% of funds specifically allocated by the Department of Social Services to serve children with developmental disabilities or behavioural disorders. At present, these monies are all devoted to special residential services. Improving the expertise and reallocating this staff resource could help create community-based, inter-disciplinary resource teams in a short time-frame. The Department's existing funding mechanisms to provide respite care, homemakers support, therapeutic foster homes, etc., could be expanded upon. Other resources such as the psycho-education assessment services of school boards, specialists in regional hospitals, and the mental/public health systems could be better used. We therefore recommend that:

> Recommendation 3: the Department encourage its PSS personnel to use available, discretionary funding mechanisms to increase the availability of respite care, visiting homemakers and other similar services --- so as to enable natural/foster parents to more adequately cope with and help children with disabilities presenting demands on the family considerably beyond those normally expected.
>
> Recommendation 4: the Department take the lead in initiating a planned approach whereby social services, mental health. education, public health, justice and the many other programs and agencies having an interest in a child can work together in a coordinated, holistic and integrated manner.
>
> Recommendation 5: immediate steps be taken for the retraining of programme personnel within the WFR.

Recommendation 6: the WFR personnel and programs be reorganized so as to allow for more inter-disciplinary collaboration internally and, at the same time, to achieve better interface with community service personnel; and

Recommendation 7: a three-phase process be followed whereby WFR resources would be re-allocated to establish a dynamic, community-based service network for disabled children and families in their own region of New Brunswick.

One of the most fundamental questions we addressed throughout this whole exercise was "Why, in 1983, should any child be admitted to an institution?". The evidence from experience elsewhere and in the literature, as well as our observations in this study, suggest this practice is only of limited help at best and positively harmful at worst. On the other hand, there is considerable evidence that properly supported services in or near the childs home, in a normal environment, have a much higher likelihood of success. In the final chapter of this Report we outline a Three-Phase Plan whereby New Brunswick might move from a dependence on institution-focused to child-focused services in the community.

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I. INTRODUCTION

This Report is about children. Some have significant impairments or learning difficulties. Some act out in ways society finds difficult to accept. Some have been abused. Some are simply abandoned or rejected. Most are troubled, but all of them are children.

The children addressed here all need attention, and to be nurtured for their gifts. Many need special treatment, education or support. All need to have a chance at fitting into their community. Above all they need the love and support of understanding and patient parents or foster parents, counsellors, teachers, psychologists, social workers, nurses, doctors and the many others who care.

Specifically, this Report is about those children either in or at risk of being admitted to the Dr. William F. Roberts Hospital School (hereafter referred to as "the WFR"). The Report examines who the children are, reviews the available resources with special attention given to the WFR, and makes recommendations as to future steps the Government of New Brunswick should take in order to serve the children better than at present is the case.

TERMS OF REFERENCE

Commissioned by New Brunswick's Department of Social Services, the general rationale for this study of the Dr. William F. Roberts Hospital School is reflected by the following statement:

> "Studies have been commissioned for this facility from time to time over the past ten (10) years. Action often followed the reports submitted, but only to varying degrees. With the growing emphasis on deinstitutionalization and in view of the government, and particularly of this Department's commitment to the developing of community-based services accessible to all residents of the province; in view also of the determination of the Institution to

play a meaningful role towards the care and treatment of children with psycho-socio and emotional handicaps, it appears crucial at this time that a thorough study be made of that particular resource.

This study would be timely considering the present effort by the government to examine social program/service delivery in the province. The findings of this study should help point to directions which would ensure the best possible use of the resources available."

Specific Terms of Reference for the study are outlined in Attachment 1.

While the beginning point for this study was the WFR, it was understood from the outset that the WFR is but one component of a much larger network of services in New Brunswick for children with conditions of mental retardation, neurological impairment or exhibiting emotional/behavioural/social problems. As such the evaluation team was encouraged to examine the broader context within which the WFR exists and from which WFR clientele come.

CONTEXTUAL ENVIRONMENT

The quote above alludes to four factors in the New Brunswick context that form part of the environment in which the study was conducted -- previous studies of the WFR, changing global assumptions regarding service forms, government organizational review and economic conditions. A fifth, vital component is the prevailing "culture" in the civil service and the larger society. A brief review of this contextual environment at the outset is useful simply because these several variables will affect the extent to which changes recommended in this report are likely to be implemented.

Previous Studies. No fewer than six reviews of the role and functioning of the WFR have been conducted since 1974. It therefore is not surprising that a sceptical attitude existed amongst certain staff and others as to whether this study was either necessary or would contribute to substantial change. This fact means there was a certain risk involved in commissioning this study. If the report is not acted on in a substantive way, there likely will be an increased scepticism as to whether government intends to clearly re-define the concept of services for children; and, those who are content with an institutional approach to service provision will have their views reinforced.

Changing Global Assumptions Regarding Appropriate Service Forms. There has been a substantial change in assumption as to the form services for children or adults having disabilities ought to take. Increasingly, professionals, parents and advocates throughout the world have come to the conclusion that residential institutions are an outmoded, ineffective form of helping individuals with disabilities. It is apparent that this new wave is here to stay. In this context, review of the WFR is entirely appropriate.

Government Organization Review. The initiation of this study coincided with the beginning of a review of the government's existing organizational structure. As a consequence, we were aware that the implications of this study had potential relevance beyond the scope of the study itself.

Economic Conditions. The Province of New Brunswick is in a period of economic restraint. The mandate of the Office of Government Reform includes an examination of ways in which public sector costs might be saved or cut. It therefore, is timely to examine whether less costly forms of human service may be substituted for those of greater cost.

Cultural Dimensions. Not to be underestimated as an influencer of outcomes is the "culture" that has grown up in the civil service itself, and an analogous "culture" in larger society. Bureaucratic culture (whether in government or in large-scale private enterprise) is notoriously resistant to change. Therefore, any attempt at change will require extensive "will" on the part of both politicians and senior public servants. Similarly, in the larger society there is a population that has presumed it appropriate to send children to an institutional setting when they are deemed "out of control". Whether a child as young as 4 years of age should be so deemed by any reasonable standard is another matter, as this Report will show. More to the point is that such a pattern reflects a certain cultural entrenchment which will require assiduous attention if it is to be altered.

THE TEAM

The study team consisted of:

Dr. Reginald Babcock, a Consultant with the Applied Research Consulting House, Mississauga, Ontario, who has his doctorate in developmental psychology, and extensive experience in setting up and managing services for children with a wide range of conditions. Dr. Babcock has participated in evaluating more than one hundred health care, mental retardation and other facilities.

Mr. Don Cornish, M.S.W.. C.C.H.S.E.. is the Executive Director of Huronia Regional Centre, Orillia, Ontario the oldest mental retardation facility in Ontario. which is actively reducing its population. He has had extensive previous experience in managing regional social service systems and developing social service policy in Ontario.

Mr. Ron Elliot. M. Ed. is Director of the Evaluation Branch, New Brunswick Department of Education. Mr. Elliot has extensive previous experience as school superintendent, evaluation of a wide range of educational programs, and in policy formulation.

Mrs. Pauline Desrosier-Hickey, M.S.W., is Director of Research within Program Planning and Development, New Brunswick Department of Social Services. She has had extensive experience in evaluating childrens' services.

Mr. Reuben Orenstein, M.S.W., is Program Consultant for Children's Residential Resources in the Department of Social Services, and replaced Mrs. Desrosier-Hickey during her illness. Mr. Orenstein is intimately familiar with all facets of children's services, both centrally and regionally.

Dr. Aldred H. Neufeldt, is a Principal of the Applied Research Consulting House, Mississauga, Ontario and Visiting Associate Professor, Human Service Organizations, York University. In previous positions, Dr. Neufeldt was Director of the National Institute on Mental Retardation and Director of Operational Research for Saskatchewan's provincial mental health programs.

Dr. Neufeldt was commissioned to chair the team and take responsibility for preparation of the final report.

STUDY APPROACH

Figure 1 describes in general terms the process followed as team members individually and in groups (sub-group and group-as-a-whole) addressed themselves to the complex variety of issues to be faced. The team began by considering the broad contextual factors and, over time, proceeded through the various steps gradually narrowing its focus to future tasks required. Major steps included:

1. Scanning the human service system pertaining to children served by the WFR. This involves asking questions such as: Who are the children? How representative are they of other

Step:

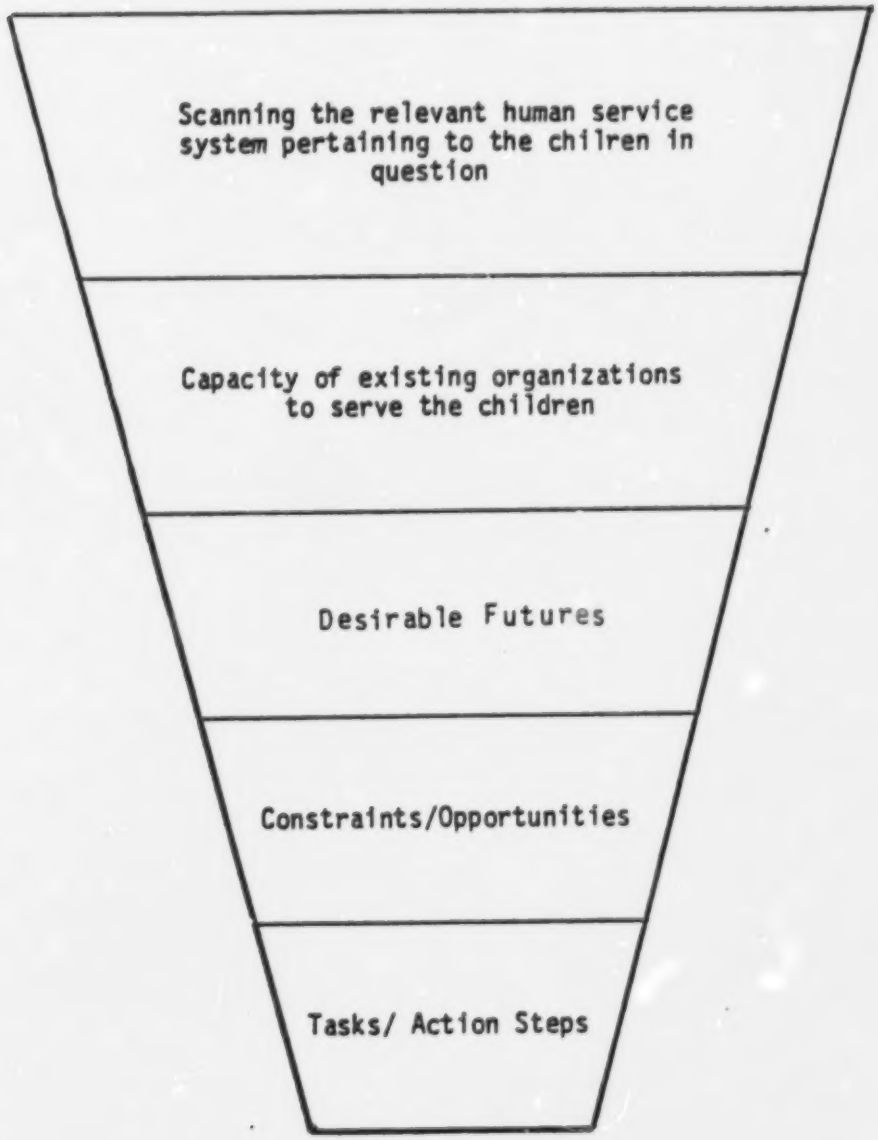

Figure 1: An outline of the general process followed in examining the complexity of issues relevent to the future of the WFR.

children? Where from and how do they get referred to the WFR?

2. Examining existing relevent organizations related to children in question (i.e., education, justice, mental health, social services, etc.); their capacities to serve the children in question; where the WFR fits; its capacity to serve the children; problems encountered in all of the foregoing.

3. Projecting desirable futures; i.e., what is it that is most appropriate for the children in question?

4. Examination of constraints and opportunities to achieving desirable futures;

5. Identification of tasks implied and action steps to be recommended if the desirable future is to be reached.

The work involved was generally divided as follows:

- o Within WFR issues were examined chiefly by Mr. Cornish and Dr. Babcock, supplemented by observations of other team members;

- o Social Services, Education, Mental Health, Justice and related parameters were examined individually and/or jointly by Ms. Desrosier-Hickey/Mr. Reuben Orenstein, Mr. Elliot and Dr. Neufeldt;

- o Views from parents, foster parents, CAMR-NB, external professionals and others were solicited by all team members individually and/or collectively, depending on the occasion.

II. BACKGROUND

An institution such as the WFR doesn't just appear. It was developed with a substantial amount of thought, and for a particular time in history. Over time, the context changes making institutions of all kinds increasingly irrelevent (cf. Shon, 1971, and others). Some social institutions can make adjustments, others fall into disuse. Institutions tied to buildings have more problems adjusting than those which are not -- in part because bricks and mortar are unforgiving (i.e. special purpose buildings are difficult and costly to remodel); in part because brick and mortar based institutions are expensive to operate and maintain, but once built up are difficult to devolve.

This section briefly reviews the history of the WFR, examines who the WFR serves as contrasted against the intent, and compares the budget resource the WFR represents against other available resources for similar clientele.

NOTES ON THE HISTORY OF THE WFR

The first name for the Dr. William F. Roberts Hospital School was "Lancaster Hospital School for Retarded Children". It was later renamed in honour of Dr. William F. Roberts, the first minister of health in "this province and the British Empire."

The cornerstone for the WFR was laid on September 19, 1963. A newspaper quotation of the day states it to be "an innovation in institutional concept and design." It was built with four wings, the two largest to accomodate "educable and trainable retarded children ... (who are) to be admitted long enough for complete evaluation as well as some therapy and training which might lead to improvement and enable them to return home". A third wing was for diagnosis and assessment, and the fourth for an infirmary. The building was constructed through 1964, and the first children admitted January 4, 1965.

Students of the history of institutional services will know that in the late 1950's through to mid-1960's, the prevailing opinion of many professionals was that it was imperative to move away from the large institutions in which mentally retarded and psychiatrically ill people were housed, and in their place should be built smaller treatment facilities housing up to about 250 people (the WFR was designed for 240 people, given the standards of the day). The history of misery attendant to earlier institutions was noted at ground breaking by the first incoming Director of the WFR, Dr. John C. Stanley, who stated: "... the history of early institutions records a gradual retreat from their first programs of active treatment and training into practices of custodial care."

Simultaneous to the building of the WFR, there was a growing conviction that community-based services with education in schools, housing at home or in group homes, etc. was a more appropriate way to provide for the needs of children with mental handicaps. Indeed, in his speech at the offical opening of the WFR (then Lancaster Hospital School) on February 8, 1965, Dr. Stanley stated: "It will be agreed that the Children's Hospital School will realize its full worth when it is eventually related to adequate community services. **Indeed, it is questionable whether it can long continue to serve a useful purpose unless such services are developed"** (emphasis added). Thus, from the very beginning of the WFR, thoughtful leaders recognized the critical importance of community alternatives, a concern expressed in a number of subsequent reports and documents.

What was not recognized at the time was that in the subsequent decade even these types of mini-institutions would be found wanting. The worst fears of leaders were confirmed when, throughout North American 100 and 200 bed institutions more often than not became increasingly custodial, as had their larger ancestors. In contrast, parents and educators began demonstrating that, with proper support, children with even moderate to severe degrees of retardation could learn, and that home supports, group homes, etc. were preferable to institutionalization.

The population of WFR reached 206 by the end of F.Y. 1967-'68, and thereafter, declined gradually to the range of 150-170. In the past year a ceiling of 125 children has been set for the facility. The decline, in reasonable measure, may be said to reflect changing attitudes as to more appropriate forms of services for children. Since the early 1970's, parents within the Canadian Association for the Mentally Retarded (New Brunswick Division) (CAMR-NB), increasingly have expressed their wish to have children served close to home. In part, the decline may be related to changes in standards set as to the amount of space required for housing people in institutions, another reflection of societal attitude.

Over the years there has been a decrease in referrals of children with mental retardation. However, those have been offset by an increase in referrals of children described as having emotional or behavioural problems, so that in 1982 over 50% of new admissions were said to have behaviour problems as the principal reason for referral. However, the same questions may be asked about services to children with social-behavioural problems as for those with mental retardation. Is it desirable to take children away from their homes or a home-like environment? Can an institution in any one location, even if desirable, adequately serve the entire province? These and other questions, increasingly, have been asked in recent years.

Coincident with the changing views of public and professionals, there also has developed a state of unease within the WFR. Since 1970, it has had four different directors, and a fifth who served in an interim capacity for one year. Questioning about the validity of some of the WFR programs has led to a succession of recommendations for change, some of which have been implemented and others of which not. As noted elsewhere, the current atmosphere could be characterized as one of generalized fear that the team was there to recommend closure of the operation. Along with those fears were expressed feelings of hope that we could help them find a better and more relevant way of operating their service. Any number of staff made it known that their fundamental wish was "to know where we are going and get on with it".

Clearly, the problems and questions remain unresolved to the present. The current study is meant to address these, and provide for a strategy of change. However, the question is not simply one of "what should the WFR do?" To resolve this question requires that we ask a more fundamental question: "Who are the children that need services and how should they be served?" It is only in answering this latter question that the former can be addressed and the issue of the WFR role resolved.

WHO DOES THE WFR SERVE?

Since the WFR has continued to receive referrals despite the many questions raised about its role, it is clear that unmet community needs have existed in communities throughout New Brunswick. To gain an understanding of the current assumptions about who the WFR serves, two types of review were undertaken: a detailed review of children currently in the WFR, and a statistical review of children admitted during the most recent complete year, 1982. More complete information on the current population may be found in the program review provided in a separate document. A summary of data on 1982 admissions provided

by research staff of the WFR is summarized in Attachment 2. Significant observations from both sources include the following:

Statistical Characteristics of Children Admitted in 1982.

- o A total of 131 children were admitted in 1982, 50% new admissions and 50% readmissions (the file on one child was missing so the data is calculated on a total of 130.)

- o Of 1982 admissions, boys outnumbered girls 2:1. Nearly 60% (50 of 88) boys were new admissions, but over 60% (27 of 42) girls were readmissions. However, of those children staying beyond respite care the boys outnumbered the girls 4:1.

- o Only 8 of all children spoke French as their mother tongue. For another 8, the language was either not stated or both French and English. The remainder (114) were English.

- o One-third of the children ranged in age from 8-12, and another 28% from 13-15 years; but 20% were 7 years of age or under (with 10 of these children being four years of age or under).

- o 97 (or 75%) of the children came from their own homes, with the remainder from foster or group homes (except one who was from out of province).

- o The largest number of children admitted (57) were from the Saint John Department of Social Services (DSS) Region (44%). The next most frequent admissions came from Moncton and Fredericton DSS Regions. The remainder of the province sent relatively few.

- o Approximately half of new admissions were children with normal intelligence. However, most children admitted showed some significant mental handicaps.

- o The largest single reason for admission was to provide relief care (N=63 or 48%). The majority of the remainder c.'ensibly were admitted for a variety of "behaviour problems".

- o Before examination of file data team members were advised by several different individuals that an example of the type of child admitted was the "fire-setter". However, it would appear that in only 2 instances of 130 did the setting of fires precipitate an admission.

- o Common "problems" exhibited by very young children included such precipitating factors as:

  - a 4 year old threatening another child with a knife.

- parents having difficulty toilet training a 3 year old.
- another 3 year old bit a younger sibling, knocked him off a chair injuring the child, and was, in turn, injured by the mother.
- a 5 year old expelled from Nursery School.
- another 5 year old with minimal speech development.
- several who apparently had been abused.
- etc.

Children in Care as of September, 1983.

The children resident in the WFR as of September, 1983 can be subdivided into three basic groups.

o A group of 17 boys and girls who are multiply, physically handicapped and profoundly retarded with diagnosed conditions such as spinabifida, scoliosis, post-spinal menengitis, hydro and microcephalus. Some of the children are tube-fed. Most are not capable of self-locomotion at this time.

o A second group of 16 children classified as "severely mentally retarded" who also have some physiological handicaps. Their ages range from 5 to 16 years. Most of the children on the Unit at this time:

- are not capable of self-feeding;
- are not capable of self-toiletting;
- are not capable of washing and bathing;
- are non-verbal or are in need of communication skills;
- have ambulation problems and need special training or special equipment to assist in walking;
- need active habilitation programming involving structured tasks or activities to increase concentration and co-ordination in both fine and gross motor activity;

o The third and largest group is of children who have behaviour problems and minor to major learning disabilities. As of September 20, 1983, 84 children fell in this category. Their ages ranged from 3 to 16. The children have a wide variety of needs, with a sizeable portion exhibiting inappropriate behaviour ranging from hyperactivity to temper tantrums to physical and verbal abuse of peers and staff. Most of the children have the expected learning difficulties associated with behaviour problems. The education level of most of the children is anywhere from two to four years behind their

chronological age. Of the 84, only 5 were diagnosed as having an educational level higher than their chronological age. The basic needs of the children of this group are as follows:

- learning disabilities educational programs.
- social skills in dealing with peers as well as adults.
- self-help skills such as feeding, grooming, bathing etc.
- leisure/recreational skills or interests.
- structured individualized behaviour programs helping to eliminate or replace certain maladapted behaviours such as hitting or verbally attacking peers and staff, temper tantrums and some self-abusive behaviour.

Conclusions

Several conclusions about who the WFR serves may be drawn from the foregoing.

1. The WFR essentially serves those people closest to it, with Saint John being the largest single user and at a rate disproportionate to population.
2. The WFR essentially serves the anglophone population of New Brunswick with the francophone communities remaining virtually unserved.
3. The large number of children admitted for respite care indicates the importance for this type of service throughout New Brunswick.
4. The extent to which very young children are admitted suggests either an absence of sound professional support services to families throughout the province, or only a partial commitment to keeping young children in a family context, or both.
5. Nevertheless, there are a sizeable number of children who, either themselves or their families, require an intensive form of service now not made available in the community.

RESOURCE DISTRIBUTION

An important contextual issue is the way in which resources are distributed for children such as those in question in this study. The way budgets are allocated provides a very direct reflection of where real priorites have been. If a major goal is to encourage services which support a child in his home, or a home-like environment, one would expect budget and staff resources allocated for such purposes to a significant degree. Alternatively, if there has been no real priority given to the type of children considered here, or if the priority deliberately has been to institutionalize them, then the institutional budget is likely to be disproportionately high.

The major types of budget allocations within the Department of Social Services available to serve children admitted to the WFR and others similar are outlined below (F.Y. 1983-'84, rounded to nearest $1,000.00).

	Total Cost		Average Cost Per Client Day
o The WFR	$6.6 million	(79%)	$144.00
o Special out-of-province placement	225,000	(03%)	$ 31.00 - 191.00
o Group homes	780,000	(09%)	27.00
o Nova Scotia School for Girls	551,000	(07%)	$ 86.00
o Therapeutic foster homes	80,000	(01%)	$ 20.00
o Special needs homes	84,000	(01%)	$ 13.00
	$8,320,000		

Not included are such generic resource items as basic foster care or PSS support funding.

Figure 2. outlines the way in which resources for the population in question are made available. It is evident that by far the largest amount of both person and budgetary resource is tied up in the WFR (79%). Other out-of-province institution environments account for another 10%. In other words, nearly 90% of New Brunswick DSS budget allotments especially designed for hard-to-serve children is tied to residential services which are both least accessible and least integrative in emphasis. In 1982, these resources served slightly more than 200 children. In contrast, those services which would encourage children remaining with their families and in the community are relatively under-funded.

The implication of the foregoing is that a shift in resources is required from the lower left hand corner of Figure 2 to the upper right hand corner if the province is to be serious in enabling children to remain in or near their families and communities of origin.

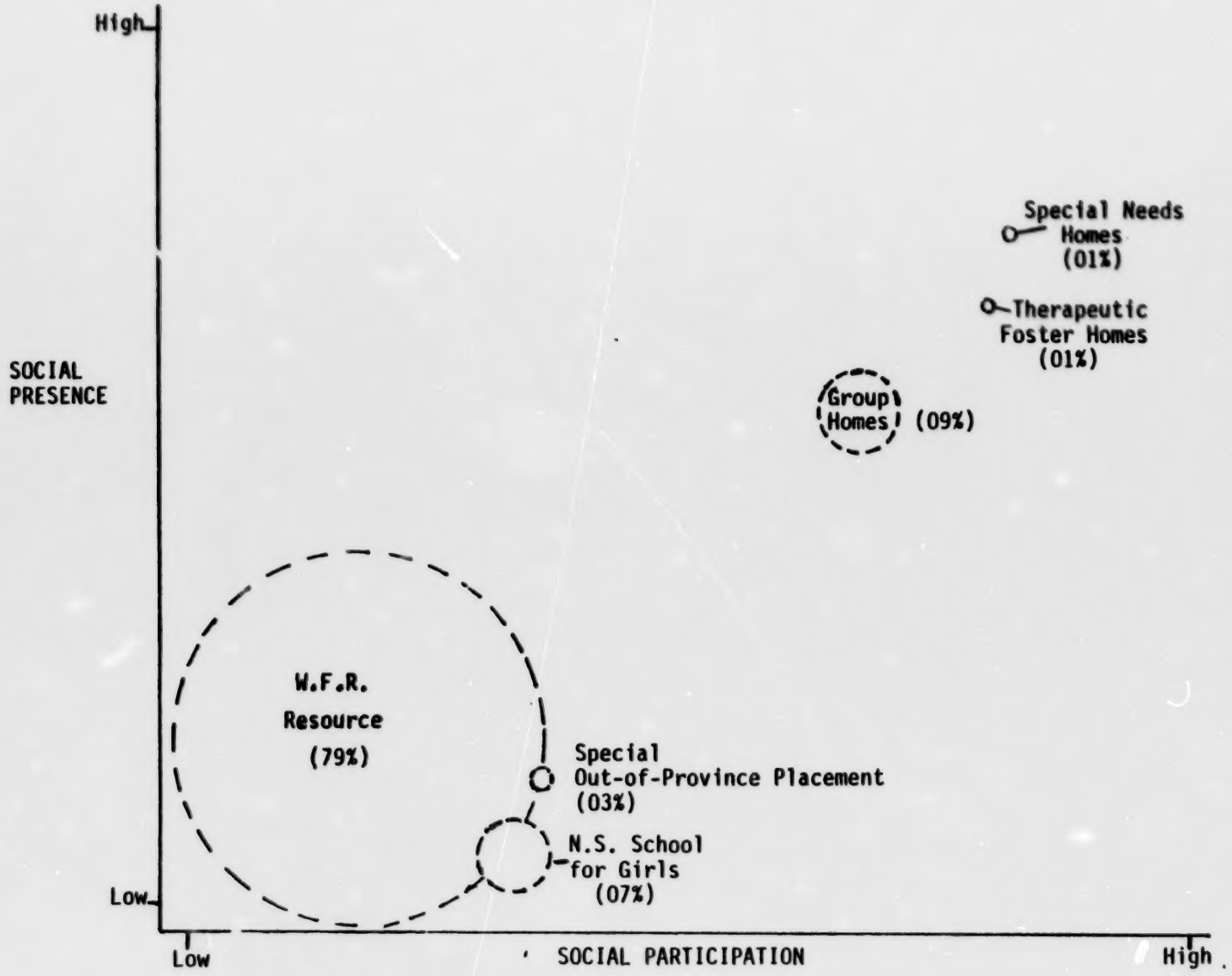

Figure 2: Allocation of Fiscal Resources for Children with Intensive Service Needs and the extent to which these resources contribute to social integration.

III. WFR ORGANIZATION AND PROGRAM REVIEW

In Chapter II, we noted that the WFR represents the most significant fiscal resource in New Brunswick for children with developmental disabilities or behaviour disorders. This resource translates into a total complement of 238 personnel. Of these, 164 (or 69%) are directly involved in clinical support roles, with the remainder (31%) in an administrative support role. A review of budget allocation indicates that approximately 4.7 million dollars (71%) is applied to clinical and education functions, with 1.9 million (29%) for administration and supplies. The question of how to use these resources, then, is a highly significant one.

The WFR has experienced a series of major problems and shifts in organization and senior administration within the past several years. This, plus other factors, led to the current review. A detailed report on program and organizational/adminstrative dimensions is provided in a Report Supplement. In this Chapter, we summarize the major and over-riding issues which must be dealt with. The conclusions presented were derived from interviews with all levels of personnel at the WFR in August and September; review of a wide variety of planning documents, correspondence, etc.; sampling of files, program material, etc.; and interviews with individuals outside of but having an interest in the WFR.

GENERAL OBSERVATIONS

Programmatically, we saw within the WFR many examples of sound professional conduct and genuine caring. This was in a context of considerable confusion and disorganization. Like many centres across North America, the WFR has been gradually shifting from a "medical model" to a "social developmental model". In part, the confusion relates to the fact that the transition in models is not yet complete. The review also takes place at a time when there is a major government reform process underway so that, understandably, there was some

uncertainty as to where and how the WFR fits in the scheme of human services in the future. It is also important to note that the role and functions of residential institutions increasingly is being questioned around the world. These various factors have led to varying views amongst staff as to the continuing value of the WFR as it exists, and what its future role ought to be.

Given this general turbulence, both outside the WFR as well as within, it therefore is not surprising that a sizeable number of problems and issues were identified. Again, to the credit of staff, many of the problems cited below have in fact been identified by various personnel internally.

THE PROGRAM

The previous chapter reviewed the kinds of children served by the WFR. Briefly, there are three populations -- multiply handicapped, often profoundly retarded children; children with severe mental retardation; and children considered to have behavioural disorders. Most of this last group also tend to have learning disabilities, although some do not and, a few may have quite superior scholastic ability. A surprisingly large proportion of the children (over 50%) were under the age of 13, a population that should be quite manageable in regular school and home programs given the proper training and support. Many of the children also came from their own homes, suggesting that interventions directed towards training and supporting the natural family should have a high pay-off in terms of benefitting the children, and thereby reducing admissions.

The program in the WFR for these children is organized along strict disciplinary lines. That is, each of the disciplines operates quite independently from the others (i.e. school from social work from psychology from residential care staff and so on). In this context, we noted that most of the staff were well intentioned and well motivated towards the children. But, good intentions and isolated, sound professional actions do not a program make. In fact, the programs which exist are fragmented and un-coordinated making it a highly risky proposition whether or not an individual child is likely to benefit. The following comments are illustrative.

- There are no individual program plans (IPPs) in evidence for the children. Each discipline independently formulates its own views as to what a child needs. There is no one place where a holistic view of a child is obtained, and decisions are made as to "who will what" for a child.

- The only seriously consistent organized program is that offered by the school. Yet, the school serves only some of the children. The children in the infirmary and those with severe mental retardation are almost invariably ruled out from the start. Other children who exhibit what to the school are intolerable behaviours (e.g. not toilet trained) are also excluded. Yet, these are the children most in need of training, and for whom the educators expertise could be well applied.

- There is an absence of co-ordinated planning effort between disciplines. Residential care staff, educators, psychologists, therapists (e.g. speech, OT/PT, etc.), leisure/ recreation personnnel and nurses/physicians all are involved in programming of some kind. Yet, there is little formal connection even at a program level. While the Directors of these various departments meet, individual teachers are not supposed to discuss an individual child with a psychologist or residential care staff member. Social workers are not involved at all in program planning. Social workers manage the child review and discharge process. Teachers may find out about a discharge only after the fact. A new Clinical Team concept is being instituted as of this writing. However, no educators are involved thus limiting the team's usefulness. Such within-discipline focussed behaviour severely inhibits programming possibilities.

- A Pre-Admission Unit (PAU) was set up in the spring of 1983 to conduct intake assessments lasting up to 30 days. This unit was only partially operational by fall. While the PAU process was followed for boys, it was not for girls. No systematic systems were in place to gain precise baseline measures on behaviour, calling into question the current assessment capability. Furthermore, PAU staff meet only once a month to review the children, which means that a 30 day maximum becomes a 30 day minimum stay.

- The WFR is largely isolated from community resources. Virtually the only point of access is through the social work department, yet it is clear that there has been only a limited amount of contact between the WFR social workers and community service personnel throughout the province. As of September, only 3 children at the WFR were attending regular schools in Saint John. Similarly, there is only limited contact with other resources in the region such as the Regional Hospital, etc. The net result is that the WFR is inward looking, with dynamics around many present transactions having a "we/they" characteristic.

THE PROGRAM/SERVICE MODEL

The WFR was originally developed to operate largely on a "medical model" basis. Some years ago, a shift was begun towards a "socio-developmental model". In general terms, it is this latter model which present staff espouse. However, it is evident that the shift is not yet complete. This is evident both in the way the organization is structured (i.e. on discipline lines rather than inter-disciplinary program lines), and in the fact that no clear consistent developmental programs are in place. There have been several attempts to define the facility as either a "training" centre or an "assessment resource centre". While to some degree these functions are in place, in reality the WFR functions primarily as a residential placement centre. That is, a close review of the program demonstrates that the WFR serves principally as an "escape valve" for community service providers. Internally, the absence of child-centred, co-ordinated program planning and implementation between disciplines/staff groups means that living in the residential setting becomes the predominant factor influencing the child.

DOCUMENTATION

Sound documentation procedures are essential for both good program and administrative practice. Regretably, virtually all areas examined indicated inadequacies in this area. In program areas:

- o few good examples of sound baseline measurements on child performance could be found;
- o clinical/program records on individual children were kept in a variety of places with no one place having all relevent data on a child;
- o documentation of child performance goals were vague and frequently absent;
- o in the infirmary, inadequacies were found with respect to seizure charting;
- o a variety of disciplinary procedures were used without adequate rationale or documentation, thus creating the potential for child abuse;
- o etc.

Similar inadequacies of an administrative nature were found, including:

- o outdated policies and procedures documents;
- o standards for maintenance of master files on children were not well developed;
- o minutes of meetings and associated documents were frequently not kept, or if kept, were inadequate;
- o few procedures were in place to conduct effective staff performance evaluations and/or make staff accountable for their performance; and,
- o there was an absence of administrative goals with specific time-frames.

ORGANIZATION

A sizeable number of organizational issues were identified beyond those already specified. These are exemplified by the following:

- o No consistent organization structure. The internal organizational structure has had numerous changes in the past several years. This has led to an unclear sense of who is responsible for what.
- o Need for clinical leadership. There has been a need for co-ordinated program leadership for some years. A clinical director was appointed approximately one year ago, but left when conflict developed between the director of the centre and the clinical director. At present, no unified program co-ordination is being exercised.
- o Span of control. The entire organization has a very flat structure wherein the director acts as both administrator and clinical director. At this and several other points in the organization chart, an unusually large number of individuals report to a single person, (e.g., the Supervisor of Residential Care is in fact directly responsible for supervising over 100 staff). This is a questionable arrangement.
- o Program Team Structure. Up to the point of this study, no permanent program teams existed. Recently, there have been some initiatives in developing such teams. However, the teams

as proposed leave a number of outstanding issues such as: Who will be the leader of the team? To whom are the teams accountable? Why are certain groups such as educators not included in the team? etc.

- o Appropriateness of Management/Staff arrangements. Only eight of the 238 positions are viewed as "management" and outside the scope of the unions. Since many of the supervising staff belong to a bargaining unit, the process of supervising one's brother or sister in a union becomes somewhat tenuous. There also is a perception that management could not move direct care staff from one unit to another without the consent a union. Both factors present definite problems in ensuring quality programming. While we highly endorse a collaborative decision-making process, the current "management/staff" arrangements lend themselves to development of significant problems.

- o In 1982, more than 2500 days of staff time were lost through illness (an average of 11.65 days per employee). While not out of line with other large institutional settings, this should be considered excessive.

- o Training issues. The centre has a full-time in-service education person. While approximately 5,700 hours of training were provided for staff in the past fiscal year, there seemed to be no consistent pattern to the training that related to a coherent program direction.

THE PHYSICAL FACILITY

The physical facility is typical of institutions planned in the 1950's and '60's -- a long flat-roofed building with four wings leading off a long hallway. The physical plant itself is kept very clean and in reasonable condition. At the same time, there is very little personal space available for residents. The residential area in reality involves a number of wards housing up to 20 or more children each. There is little in the environment which is typical of a "normal" setting making it difficult for children either to feel "at home", or for them to generalize what is learned here to a normal situation.

THE LOCATION

The location of the WFR presents a number of problems. First, given that the WFR is located in Saint John, it is a long distance away from much of New Brunswick's population. Thus, for any resources to travel out from the WFR becomes as problematic as for people to travel to the WFR to access potential resources.

Second, even within the Saint John region, the WFR not easily accessible. It is located outside of the city of Saint John near a small bay on a road leading to a gravel pit. There are some houses nearby but these are not part of the developed Saint John area. Next to the WFR is a graveyard on one side and extensive open space on the other side. No public transportation is available to the WFR, so that the only means of access is by automobile.

SUMMARY OF OVER-RIDING ISSUES

A number of over-riding issues appeared throughout our review of the WFR, and are described more fully in the Report Supplement. These are summarized below. If the resource represented by the staff and budget of the facility are to be best used on behalf of those children in New Brunswick who, without question have serious needs, then these over-riding issues need to be addressed effectively.

First, it is evident that **no consistent, clearly defined vision** is in place of how children in New Brunswick having multiple needs ought to be served. Personnel within the WFR themselves have had various views, reflecting in reasonable measure the doubts and concerns of the larger community. Most staff interviewed recognized that children should ideally be served at or near home. At the same time, some argued strongly that 30 day assessment and residential facilities were appropriate. Clearly the Department of Social Services needs to establish Statements of Principle, Mission and Goal Statements, etc. so that detailed program planning can be undertaken by WFR personnel. The Main Report begins this process by identifying the nature of the children to be served, desirable service and staffing patterns, etc.

Second, there is **no coherent program model** in place at the WFR. A shift has been made away from a "medical model" some years ago, but there seems to have been difficulty implementing a psycho-social "child development" model. Bits and pieces of various micro-models are in place (e.g. behaviour management, counselling, 30-day intake and assessment, etc). Attempts at training are fragmentary at best. The net result of this fragmentation is that the WFR in reality, operates overwhelmingly on a "residential child maintenance" basis. An

individual program planning approach to implementing a "child development" model of service is strongly recommended.

Third, there is a need for a consistent internal service delivery system to be put into place oriented much more directly to the needs of children. The current organizational structure is such that department/discipline roles are more important than children's needs. To counter these tendencies, we will recommend elsewhere a reorganization so that discrete inter-disciplinary teams are established, each responsible for specific children.

Fourth, there has been an **absence of planning** within the WFR for some time as is evident by dated policies and procedures as well as the ad hoc nature of many of the programs and activities observed. Some progress seems to have been made in this area within the past year, but there still is an extensive amount of work to be done before one could say the organization was operating well. Both short-term and long-term plans need to be established in all facets of the WFR consistent with the Mission, once it is established.

Fifth, communication problems of many kinds have existed, both within the WFR as well as between the WFR and other entities. Communication between programs and disciplines is tinged with a self-protective tone leading, in the end, to mutual suspicion. Regretably, the children suffer as a result because joint approaches to programming have been ruled out to date. Similarly, the WFR as a whole has created a gulf between itself and the other services throughout New Brunswick (aided, no doubt, by agencies who wish to "dump" their problem children in the WFR). Contact between the WFR and regional community service personnel occurs with limited frequency. Very limited use is made of available resources even in the Saint John area such as regular schools, the mental health clinic, paediatric and other specialty resources at the Regional Hospital, etc. Finally, contact between the WFR and the central office of DSS has been characterized by a "lack of trust" which will take some effort to overcome.

Finally, it is evident that superior leadership will be required in order to move from the current status to a more desirable one. The leadership in place must know a good program from a bad one; must be able to understand and implement more desirable service models; must be able to motivate staff to become child-centred and forget inter-disciplinary rivalries; and must be able to rise above petty bickering. In our opinion, most of the current personnel could probably rise to such a challenge; but they will require an infusion of external energy and ideas.

IV. CAPACITY OF THE LARGER SERVICE SYSTEM

A variety of resources exist throughout New Brunswick with which children usually come into contact before being referred to the WFR. In many respects, it is a break-down at this level that subsequently leads to institutional placement. In this chapter, we review in some detail two of the more significant of these; namely, services made available through the Department of Social Services; and, educational services. There also are a variety of other specialized resources with whom the children or their families may come into contact. Several of the more significant of these are reviewed; namely, mental health services, those made available through the Department of Justice, parent associations and regional hospitals.

A. SOCIAL SERVICES

The Department of Social Services, through the Division of Personal Social Services (PSS), has the mandate to provide a wide range of community-based services to children and their families on a protection basis in accordance with the Child and Family Services and Family Relations Act. Specifically, the Department has the responsibility to respond to any request for service when a child's security or development may be at risk, and may intervene with support services to the family, or provide alternate care for the child when intervention with the family would prove inadequate. Although the Act allows for the general provision of social services, at present the Department does not have a well-developed program oriented to children with developmental disabilities or behavioural disorders. This absence of specific program leads to a certain amount of ambiguity within the Department as to the extent to which, in fact, DSS has a mandate to involve itself with families having children of this nature. In general, therefore, **it would appear desirable to amend the Act and/or the Regulations pertaining thereto** so as to clearly indicate the Department's responsibility as the lead Ministry for children with developmental disabilities, physical and behavioral disorders.

The Department's current range of services is delivered through seven regional and thirteen branch offices across the province.

1. Relationship of the Department with Other Government Agencies

The Department of Social Services is part of a larger range of human service agencies involving mental health, education and corrections. Relationships between the four agencies have been informal, and the degree of co-operation and co-ordination has relied largely on personal working relationships among field staff. As a result, the degree to which efforts have been co-ordinated varies considerably from region to region, but generally would be viewed as inadequate.

Within the past two years the Department has begun to negotiate working agreements which will attempt to co-ordinate services on an equitable basis provincially. These agreements, either in place or still under negotiation, deal largely with protection services, and include working with the police on reported abuse situations, and co-operating with the schools on abuse cases, unmarried mothers and single adolescent parents.

2. Regional Soft Services

The regional offices of DSS were asked to provide a profile of the children with behavioural, physical and developmental disabilities both within the community and at the WFR, including (1) how many were served in the community with developmental disorders and/or behavioural disorders; (2) the services available in the community to meet the needs of children with such disabilities; and (3) the services that would be required to fill existing gaps.

The Department has little up-to-date data available on children in care. Consequently, responses to the first question required a file review. A lack of consensus among the regions on defining the type of child being studied meant that the specific information received on the number of children served was inconsistent and too unreliable to use. Nevertheless, some general estimates may be instructive.

In October, 1983, DSS was serving approximately 1850 children in various parts of New Brunswick. A Children's Needs and Resources Study conducted by DSS in 1979 indicated that nearly 60% of such children had some degree of behavioural disturbance or emotional problem, with or without mental retardation. Since there is no reason to believe conditions have changed since 1979, a reasonable estimate of children with some degree of disorder being served by the Department in community settings therefore would be approxi-

mately 900. Interviews with several regional Directors suggested that an estimate of 25% of the total (or 460) had a reasonable significant disability and/or socio-behavioural disorder similar to children referred to the WFR. Interviews with a group of foster parents similarly indicate that a reasonable portion of children in foster care have similar disabilities. Thus, while specific numbers are not available, it is evident that all regions are attempting to maintain children in community with needs similar to those presently being treated at the WFR.

The most consistent support resource across the province in protection services is the front-line social worker who is responsible to assess the child's and family's needs, provide counselling and attempt to procure other required services. The social worker may make available financial assistance or enable the family to access certain other services such as homemakers, day care/nursery school, tutoring etc. In part, availability is limited by the amount of money budgeted for these purposes. It is precisely on this point that the greatest ambiguity exists amongst regional personnel; i.e., precisely for whom are such resources potentially available.

Regional workers also are able to access a variety of other services, most provided by other agencies, including: foster care, mental health clinics, public health services, school social work services, sheltered workshops and a variety of diagnostic and treatment services in general hospitals. Other services are available in only one or a few regions: special schools for the developmentally disabled (Regions 2 and 3), private clinics (Region 3), private family counselling agencies (Regions 1, 2, 3 and 6), and specialized day care (Region 5).

3. Community-based Residential Resources

Four kinds of community-based residential resources have been developed:

- o Group Homes. Currently there are 13 group homes throughout the Province, 9 to serve children with behavioural or emotional difficulties and 4 to serve children with developmental difficulties or who have multiple handicaps. All group homes are privately run by community boards, while the Department provides 100% of the operating funds. All but one of the group homes are of the "parent-model" type. A couple is hired as houseparents, to live in and look after six children. Relief is usually provided on alternate weekends and one evening a week. One home for disturbed children outside Bathurst hires staff to work on a rotating shift basis.

- o Therapeutic Homes are specialized foster homes for one (and occasionally two) children with emotional difficulties. The Department has begun to develop these on pilot basis within the past two years. Foster parents are specially selected for their ability with difficult-to-serve children, and are given additional training and support. Therapeutic homes presently exist in Campbellton and Fredericton, with a similar project underway in Saint John.

- o Special Needs Homes also are specialized foster homes approved to look after three or more developmentally disabled or multi-handicapped children.

- o Foster Homes. The Department's major alternate care resource is the regular foster home. Every region has, within its network, a few excellent families who have the capacity and skill to work with children with special needs. In early September, there were approximately 45 such families across the Province with the capacity to care for 67 children.

  Table 1 and Figure 3 shows the distribution of these resources by region (not including regular foster homes). An examination of the data indicates that regional disparities exist. Attachment 3 and Attachment 4 illustrate the average present annual cost per child for each type of community residential resources.

4. Out-of-Province Placements

Occasionally, referrals are made to out-of-province. From April 1, 1982 to March 31, 1983, a total of twelve children in care were placed outside New Brunswick. Attachment 5 provides a breakdown of where these children came from, where they were placed, and the cost. Seven of the children are in residential treatment centres in Ontario, one is in a training school in Ontario and three are at the Bonny Lea Farm in Chester, Nova Scotia. All of these facilities, except the training school, are highly specialized group care facilities, offering an intense ratio of child care workers to children, and backed-up with professional (psychiatric, psychological and social work) staff services. Virtually all of these facilities offer a structured therapeutic program in a family-like supportive environment. Some, like Ausable Springs, have moved away from a network of group homes for 6 children each, to a model whereby most children now live with specialized foster parents who are tied into a network around a group home, and given back-up support by a professional staff.

An examination of the 12 children placed out-of-province indicates that 9 had been residents of the WFR. Their average stay was 37 months, ranging from six months to over 6 years. Attachment 6

TABLE 1

DISTRIBUTION OF COMMUNITY RESIDENTIAL RESOURCES BY TYPE AND REGION

Region	Group Homes				Special Needs Homes		Therapeutic Homes	
	Behav./ Emot.		M.R./Multi-handicap		Multi-handicap		Behav./Emot.	
	No.	Beds	No.	Beds	No.	Beds	No.	Beds
I	2	12	1	6	2	14	-	-
II	3	18	1	6	-	-	-	-
III	1	6	1	6	-	-	3	6
IV	1	6	1	9	-	-	-	-
V	2	12	-	-	-	-	-	-
VI	-	-	-	-	-	-	4	5
VII	-	-	-	-	1	4	-	-
TOTAL	9	54	4	27	3	18	7	11

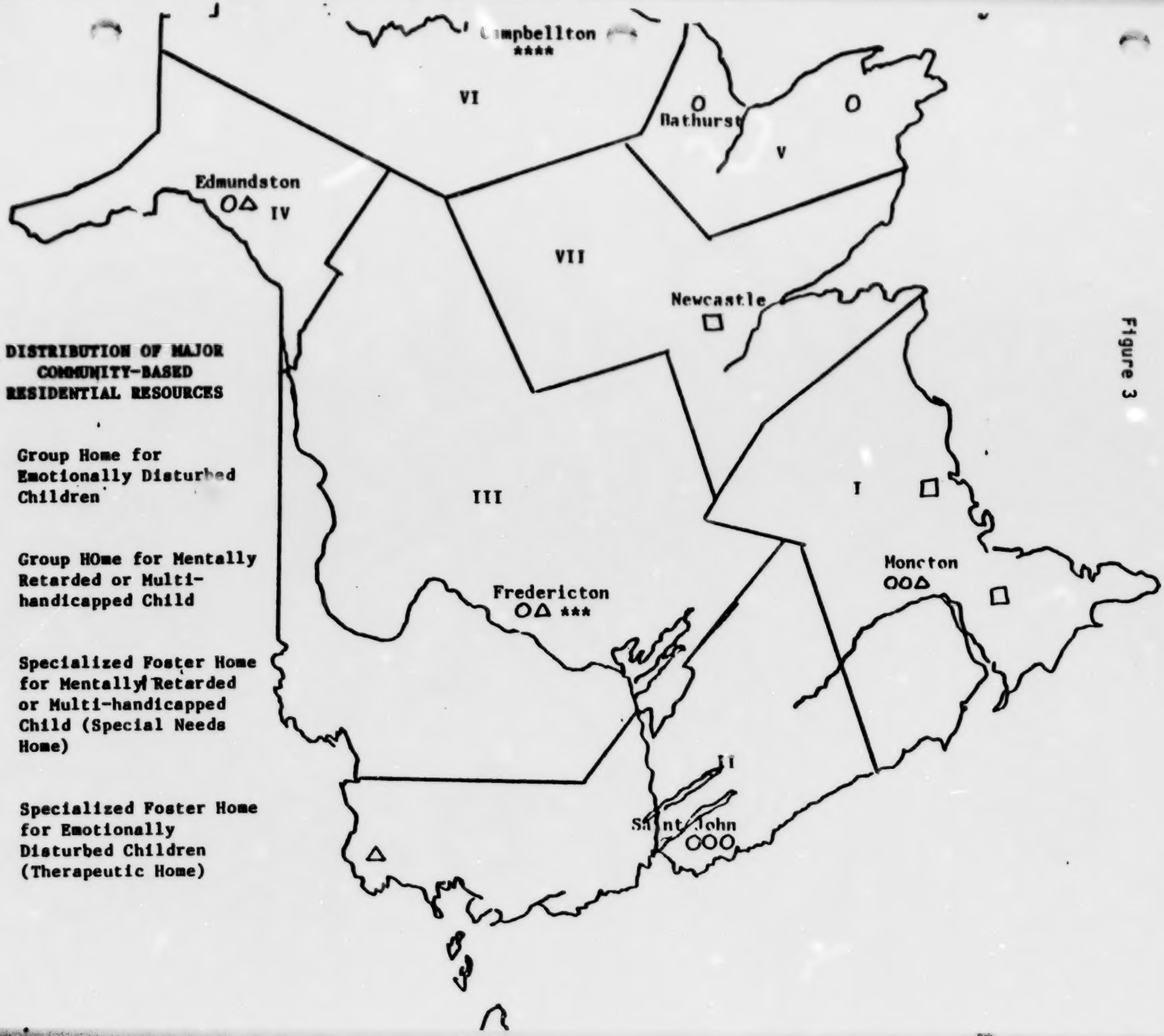
Campbellton
****
VI
Bathurst
V
Edmundston
IV
VII
Newcastle
DISTRIBUTION OF MAJOR COMMUNITY-BASED RESIDENTIAL RESOURCES
Group Home for Emotionally Disturbed Children
Group HOme for Mentally Retarded or Multi-handicapped Child
Specialized Foster Home for Mentally Retarded or Multi-handicapped Child (Special Needs Home)
Specialized Foster Home for Emotionally Disturbed Children (Therapeutic Home)
III
I
Moncton
Fredericton
***
II
Saint John

Figure 3

provides the length of placement at the WFR and reasons given for their inability (in most cases) to treat the child. On September 1, 1983 there were eleven children in outside centres, including 7 from the WFR, an eighth child who had spent 26 months in the WFR and had been discharged because he was becoming "institutionalized", and one child had been referred, and one turned down due to his age (nearly 16), lack of space and no appropriate program.

The facts on the one hand, that the one resource in New Brunswick, which theoretically should have the expertise to care for children with severe emotional/behavioural disorders sends the most difficult of these out of province and, on the other, that the less difficult children in reasonable measure, already are in the community, suggests that the role of the WFR as presently constituted is very limited.

5. Issues and Needs Identified by the Field

Two sources within, or closely related to DSS were asked to identify issues and needs from their perspective -- regional PSS Directors and foster parents. A summary of observations follows.

a. The Regions

Regional personnel were asked to examine 5 recent cases referred to the WFR to determine reason for referral, and to identify a desirable range of services in order to meet the needs of such children in their own community. Table 2 indicates the type of use made by each region of the WFR. Respite care and management of emotional/behavioural disorders top the list.

Interviews with Regional Directors indicated that the francophone regions expressed a much stronger need for alternative service than did the anglophone regions. Nevertheless, all regions were seeking an improved ability to serve children closer to home than at present they were capable of. Attachment 7 gives an indication of the kinds of service gaps Regional Directors feel there are in their ability to provide for children in their area.

b. Foster Parents

Since foster parents provide one of the most significant resources currently used by DSS, a group of 6 foster parents in one region were interviewed to determine issues/concerns from their perspective. All had some experience with children

TABLE 2

USE MADE OF THE WM. F. ROBERTS HOSPITAL SCHOOL BY REGION

Use	Region* 1	2	3	4	5	6	7
Assessment of emotional and behavioral problems	0	0	0				0
Management of emotional and behavioral problems	0	0	0		Ø		Ø
Assessment of family functioning	0	0					
Assessment of multi-handicapped children	0	0					0
Management of multi-handicapped children	0	0					0
Respite care	0	0	0		Ø	Ø	

KEY

0 - regular use

Ø - limited use

* List of Regions

1. Moncton
2. Saint John
3. Fredricton
4. Edmundston
5. Bathurst
6. Campbellton
7. Newcastle

having varying degrees of disability. The types of concerns they raised seemed both reasonable and easy to put into practice. In brief, these may be summarized as a need for:

- o involvement in planning for the children in their care during case conferences/IPP planning sessions, etc. (at present this is not the practice);
- o relief care to give families a periodic break from the pressures of handling difficult to manage children in their care (most had not received relief care for lengthy periods of time, and were unaware that the Department might assist them financially in obtaining such care);
- o in-home support, such as homemakers (a similar comment might be made as with relief care);
- o structured summer programs for disabled/disturbed children to provide both relief to the parents and meaningful growth experiences for the child (at present, foster parents assume responsibility for severely disturbed children for 24 hours per day, 7 days per week in summer);
- o a better and speedier process to reimburse them for damages caused by a child in their care (lengthy delays and arguments are experienced);
- o availability of a case aide (a person who can provide a number of administrative duties and some technical advice to the foster parent);
- o better and easier access to departmental personnel such as experienced social workers to call for consultation and advice; and
- o better information, more regularly provided, as to services the department itself has available as well as availability of therapeutic, recreational and family support services in the community.

6. Province-Wide Issues and Needs

From interviews with regional personnel, review of various documents, and by reviewing specific examples of children referred to the WFR, it is evident that a number of issues need to be dealt with province-wide so that developmentally disabled and/or behaviourally disordered children can be served at or near homes in their natural environment. A summary of some of the major of these follows.

a. Improved Co-ordination Between Agencies

It is clear from examining referrals to the WFR that virtually every child represented a case where the system failed. Usually, the child had been seen by one agency, then another, etc. Rarely did one gain the impression that agencies involved had jointly worked at developing appropriate solutions for the child's needs. There was some variation from region to region as to the amount of cooperation/co-ordination, but this seemed to depend largely on the personalities of the key actors. There is a need to develop a resource co-ordination system within each region that can plan for the optimum development and use of the available resources for children with multiple needs. As mentioned earlier, some initial agreements are being developed in the area of preventive services, but no such agreements exist to co-ordinate activities for treating difficult children either in their own homes or in alternate community placements.

b. Case Management

It is also clear from referrals to the WFR that no one agency or person has assumed the lead responsibility to ensure that appropriate service plans (IPPs) are developed for more seriously disabled children, to engage appropriate specialists and family in carrying out such plans, etc. Indeed, there usually are no service plans, nor is there any process which might reasonably approach being a viable case management system. Rather, services for children would seem best to be characterized as "crisis-response" based. Children with multiple needs require a carefully planned and phased involvement of various kinds of resource people, including teachers, parents, psychologists, physicians, social workers, etc. We would encourage DSS to formally designate itself as the lead Department on behalf of these children, and to establish a sound case management system on their behalf in each region.

c. Staff Training

The average front-line worker in DSS both lacks knowledge of, and experience in dealing with children with serious developmental disabilities/emotional difficulties and providing counselling and support to care-givers of same. At the same time, the Department has major responsibility for the care and treatment of these children outside of their own home. Yet, DSS staff could play a much more effective role as case managers, counsellors, and service obtainers if properly trained. Similarly, foster parents and group home operators need training, as do teacher aides and others. A well-planned, in-service training program needs to be introduced to

complement the development of co-ordinated community-based services. By instituting such training the community would be capable of taking care of virtually all children.

d. Timely and Appropriate Information

At the present time, front-line social workers lack up-to-date awareness of what resources are available, what vacancies exist within facilities, and guidelines for effective use of these resources. To plan effectively, the worker needs accurate and up-to-date information on these resources and decision support capabilities. The Department should be encouraged to develop an electronic management information system. Such a system should both speed up services, and could well be very cost efficient once implemented.

e. Improved Support to Existing Service Providers

At present, many foster parents end up carrying a heavy load with hard-to-serve children, often with little or no support. Similarly, in parent model group homes, the parents are responsible for the day-to-day household routine (meals, laundry, cleaning, shopping, etc.) as well as basic child care and treatment programs. These demands often lead to early burnout and/or softening of admissions criteria. The Department could make major gains by providing a small amount of additional support to both of these resources. By making homemaker and respite services available more readily, the homes would be capable of handling most, if not all, children.

f. New Community-based Resources

Without question, there is a need for additional specialized facilities at the community level: a Francophone Assessment/ Diagnostic Team, regionally based Behaviour/Training Centres and travelling Inter-disciplinary Resource Teams, as well as an improvement of of other services, such as specialized foster homes, soecial education and day care programs.

g. Co-ordinated Back-up Services

Existing specialized resources exist in isolation of each other. Often a placement breakdown could be averted if short-term relief could be provided by other resources. Behaviour/ Training Centres could back-up group homes, which in turn could back-up foster homes, etc.

h. Future Personnel Preparation

No program exists in New Brunswick to train personnel in dealing with the day-to-day needs of the child with emotional difficulties. These people are needed to work in specialized care facilities, provide respite care to natural and foster parents, work as case aides, and be part of a mobile inter- disciplinary team. New Brunswick Community Colleges do have some of the most established mental retardation counsellor programs in Canada. These should be expanded upon to accommodate the training needs of a broader range of child care workers.

B. EDUCATIONAL ALTERNATIVES

At present, legislation governing education for children with various special needs may be classified as categoric i.e., there are different pieces of legislation for children with different kinds of problems. Historically, the public school system has not been responsible for "mentally defective children, as certified by the director of a mental health clinic," and children that do not conform to the rules of the school (Sections 45 and 46, New Brunswick Schools Act). Education for children with mental retardation and cerebral palsy has been provided under a separate act, the Auxiliary Classes Act. As of June, 1983, somewhat over 900 children were attending school under this provision. Attachment 8 gives details of numbers of pupils, teachers, etc., by area of the province.

Education for the aurally and visually handicapped is provided under the Education of Aurally and Visually Handicapped Persons Act. There is no specific provision in any legislation for children exhibiting behaviour disorders. As a result, this group may easily be excluded, as noted in more detail below.

Although significant strides have been made in having physically and mentally handicapped children served by the public schools of New Brunswick, much more has to be done. In the recent past, the education of all children within public schools has become a recognized goal. A Report (Correia and Goguen) released in 1982 contains recommendations to bring the Auxiliary Classes Act into line with the Schools Act. The report supports both the movement to one comprehensive Schools Act for all children and the right of all children to an education in the least restrictive environment.

Under the current provisions of the present Schools Act, a Comprehensive Plan for Children with Learning Disabilities was

introduced in 1978 on a cost-shared basis with school districts. The Plan was developed to provide diagnostic and prescriptive services for children considered to be learning disabled in the local school district. While services vary depending on the size of the district, the plan provides for co-ordination, psychological services, psychometry, academic diagnosis, speech therapy and correction services, social work and remedial or liaison teachers. The Plan was to be implemented over a five year period. As of the 1983-84 school year, however, the program has reached only a 75% level of implementation. Even without full implementation, though, it is now possible for almost any child in the public school system to be referred by his teacher or parent/guardian for a full psychoeducational assessment with recommendations for a follow-up program. The plan is designed to be monitored through the Special Education Services Branches of the Department of Education in co-operation with School Districts and community-based advisory committees.

The Atlantic Provinces Special Education Authority (APSEA), a consortium of the four Atlantic provinces, was established to provide education for low incidence handicapped children. Under APSEA there is a residential program for severe learning disabled children. New Brunswick currently has nine chlidren in residential treatment outside the province in the learning disability program.

Under the Schools Act, school boards may suspend or expel any pupil for cause and the pupil may not return to school unless the school board concerned receives assurance from the pupil of his reform. During the 1982-83 school year, the English schools of the province suspended indefinitely approximately fifty children under 16 years of age because of behaviour related problems. While many of these children were referred to the WFR, others were referred to local mental health clinics. Many of them returned to the public schools after a "cooling-off" period. If the WFR were to close, it is this group of children for whom services would not readily be available in the public schools through protected legislation.

It would be a mistake to assume that there are only fifty English speaking young children with whom schools could not cope. It is more likely that there are many more children with behaviour problems sitting in classrooms putting in time before drifting away at age 16 when the compulsory attendance laws no longer apply. The suspension of children is frequently the system's way of demanding diagnosis and treatment from available community and provincial resources such as the Mental Health Clinics and the WFR. While there are provisions for special classes for children with mental retardation and cerebral palsy, no dollars are specifically allocated in district budgets for small classes for behaviourally disabled children. Indeed, any special classes or support services provided by boards must usually be done at the expense of regular classes or programs. In summary, the public

schools have neither the experience nor the resources to deal with these children.

Some small pilot projects have been set up recently in public schools to provide educational services in the local community for children who would normally be sent to the WFR. There is a small class for French speaking autistic children and a class for English speaking children with severe behaviour problems. It should be noted that at least one child in the community with the autistic program still had to be sent to the WFR since a suitable foster home could not be located. It should also be noted that these are pilot projects with no legislation mandating the provision of such services.

In summary then, while all services necessary to accommodate children similar to those located in the WFR are not universally available in the public schools, there is no need for an alternative structure to provide for the low level multi-handicapped children and the moderately to severely retarded, although there would be a need for physical modifications to school buildings and additional financial resources. There is, however, no structure to provide for that group of school age children who have not acquired the necessary adaptive behaviour to function in public schools. In the case of the former, additional financial resources would enable the public school system to provide education for them; in the case of the latter, there is a need for both structure and resources and attitudinal changes. With one Schools Act guaranteeing the right to an education in the least restrictive environment for all children and, if the resources were made available for the personnel, services and programs for all exceptional children, and if attitudes change quickly enough in the public schools, the public school system could provide education for all children currently housed at the WFR.

C. MENTAL HEALTH SERVICES

Mental Health Clinics throughout New Brunswick clearly represent a significant possible resource for many of the children admitted to WFR. Indeed, a sizeable portion of children admitted are either directly referred by Mental Health Clinics or have been seen by such clinics. It therefore seemed appropriate to ask questions such as: to what extent do Mental Health Clinics see children with behavioural/emotional or situational problems, mental retardation, etc.? For what purposes and to what end? Answers to these and similar questions are only partly available at present.

The Mental Health Service Division of the New Brunswick Department of Health has two exercises underway which promise to provide some greater clarity. The first is a study of mental health services for children and adolescents in New Brunswick conducted under the direction of Dr. Alex Richman of Dalhousie University, which has sampled actual practices of Mental Health Clinics between 1975 and 1980. The second is an audit of current practices by field staff of different service agencies pertaining to children seen by more that one service which was prepared for a Planning Committee on Mental Health Services for Children and Adolescents. Representatives from the Departments of Education, Health, Justice and Social Services and from professional groups sit on the committee.

Preliminary data from the Richman study indicate that approximately 6200 children were seen by mental health clinics during the 5 year period under review. The distribution of where these children were seen suggests that mental health clinic services are reasonably accessible throughout New Brunswick. Richman observes that a large number of patients were seen for non-psychiatric reasons. In the time period January 1, 1975 to June 30, 1978, the two highest frequencies of diagnosis for children seen were for:

- o behaviour disorders of childhood; and
- o mental retardation.

The five main reasons for referral to mental health clinics were:

o assessment	24%
o school problems	15%
o behaviour at home	11%
o adjustment, relationhip & management problems	09%
o learning and developmental problems	08%

These reasons are remarkably similar to those for children admitted to the WFR.

Mental Health leaders recognize that current resources are not optimally co-ordinated. Data from interviews supported by reading suggests that several significant issues need to be dealt with if service co-ordination is to become a greater reality.

First, a consensus needs to be developed between agencies/departments as to what their respective roles ought to be vis-a-vis children in need. Should mental health personnel be resource people to children supervised by social services? If yes, should these services be available only in mental health clinics, or should personnel be available for assessments and/or consultations in school/at social service settings/group homes/etc.? Who should be responsible for residential treatment programs in hospital? In group homes? In foster homes? To children and families in their own homes? It is clear that both Mental Health and Social Services have reasons to

be involved in all these areas. A solution to "who does what" will required a creative development of over-lapping resources so that current gaps in service are closed, and so current practices of pushing a child from one resource to another are replaced by conjoint involvement.

Second, specific service requirements need to be identified and joint agreements arrived at as to how such services will be provided. For example, personnel in Social Services, Justice and other agencies have a significant need for sound assessments. Mental health personnel appear not be see themselves simply as providers of assessment services. At the same time, the assessments provided do not always meet the needs of Social Service agencies according to personnel interviewed. This raises a question of who should conduct assessments? Where? Alternative options would include: establishing contracts with private psychologists, psychiatrists, etc.; and/or an alternative assessment mechanism on a staffed basis.

D. DEPARTMENT OF JUSTICE

The Department of Justice is involved with children and adolescents who in some way act in violation of the law. Though statistical data was not provided, it is clear from interviews many of the children who are apprehended have serious psycho-social problems, psychiatric problems and/or have mental handicaps. In this regard, then, there appears to be a significant overlap in types of children dealt with by Justice, Mental Health, Education and Social Services (either in the community or at WFR).

The Department at present, operates the Kingsclear Youth Training Centre for boys. Girls may be sent to a Training School in Nova Scotia. However, Justice personnel attempt to have children in alternative resource centres if possible. In this respect, they look at the WFR as a significant resource for certain of the children -- both to provide assessments as well as to provide residential treatment space. Other adolescents may be sent to psychiatric units if required or, if all resources have been tried, youths may be sent out of province.

The demand for services is expected to rise sharply in the next several years as provisions of the federal Young Offenders Act are implemented. In particular, provisions requiring more in the way of pre-trial assessments, a raise in age from 16 to 18 in definition of "youth", and other factors are likely to mean that more space will be required for:

- o holding children/youths for pre-trial assessments;
- o retaining children for 24-48 hours on police orders; and,
- o open-custody treatment residential space.

From a Department of Justice perspective, some of the space at WFR would meet their requirements. Several questions would need to be addressed to deal with such an eventuality.

First, is shared used of WFR by Justice and the Department of Social Services a desirable goal? Justice from its point of view, appears to view such an option as desirable in that it would hope to minimize costs for resources provided by the Department of Social Services such as psychological/social work/school personnel already at WFR, cost of operating and maintaining the physical plant, etc. Two significant problems exist with this option.

- o Implied image for children resident at WFR -- public perception tends to impute the most severe characteristics on residents of any institution. There is little doubt that were youth on custody orders to reside at the WFR, all children would be at risk of being viewed as "dangerous" or a "public nuisance"; and,

- o Assumption that larger residential treatment centres are a desirable form of service. Shared space use presumes children or adolescents with other needs will also continue to be housed at the WFR. As discussed elsewhere in this report, such a presumption would not be consistent with the best available data on how to work with children/adolescents whether having developmental disabilities or exhibiting behavioural problems.

Second, would Justice be interested in taking over the entire building if available? At present, their intent principally seems to be in having one wing. If Social Services were to shift its operation to a more community base, then Justice personnel would need to decide whether it is desireable to operate an institution the size of WFR for only youth in its own jurisdiction.

E. OTHER RESOURCES

A variety of other groups and agencies not discussed earlier should be mentioned as having a significant interest in services for children in question.

1. Parent Associations

The Association for Children with Learning Disabilities, and the Canadian Association for the Mentally Retarded (CAMR), New Brunswick Division at present are the only two sizeable groups of parents in New Brunswick organized to advocate on behalf of its children with special needs. The CAMR-NB has long advocated both improved services within the WFR and improved community services. Both official representatives of CAMR and other individual parents interviewed provided a variety of examples of where existing services appeared to be un-coordinated, inflexible and occasionally, counter-productive. Central views of parents interviewed regarding the WFR may be summarized as follows:

- The most desirable place in which services like those provided at the WFR is in the community -- assessments, consultation, developmental day programs, residential services, etc. From their view, all services currently provided at the WFR should be made available in community-based settings throughout New Brunswick. Indeed, the CAMR-NB was very clear about its position that the WFR should be closed and resources used alternatively.

- Some parents expressed great concern, though, that the government not simply close the WFR and "dump" their children. Closing of the WFR should be accompanied by a sound community service development plan.

2. Health Resources

New Brunswick already has in place, and is developing, a variety of health resources that have not been well used for the children in question -- either in the community or at the WFR. Public health nurses, general practitioners, paediatricians and other specialists at Regional Hospitals, etc. seem to function in isolation from other services as much as any of those previously mentioned. There are, for example, 120 Certified Family Practitioners throughout New Brunswick. These various resources represent a base of service and expertise that should be drawn into a regional service network.

3. Community Colleges and Universities

A final example of a resource base not well drawn into the service network is that provided by community colleges and universities. Their potential for personnel training is self-evident. As well, the universities/colleges have individuals with expertise in areas of potential use to regions. Infant stimulation, bio-medical engineering and other examples might be given.

V. WHAT DOES NEW BRUNSWICK WANT FOR ITS CHILDREN?

Previous chapters have identified a number of pressing problems both within the WFR, and in existing community-based services throughout the province. Identified as well were some of the existing resources which can be built upon.

The bottom line question is: "What does New Brunswick want for its children?" For it is in how any people deal with the most vulnerable of its members that the true humanity of that people is determined. The children referred to the WFR by any measure must be viewed as amongst the most vulnerable in New Brunswick.

A. THREE CHILDREN

To provide some focus for the question, consider the following brief vignettes. Although certain characteristics have been altered to protect the childrens' identities, the facts presented are true as determined from interviews and review of files.

> Susie is a bright, attractive, friendly eleven year old. She was referred to the WFR by her social worker because she was alleged to be "promiscuous". But the facts of the matter are that Susie's mother seems to be somewhat of an immature person who has attracted several men into her life who, in turn, have exploited Susie. Is an eleven year old girl "promiscuous"? We doubt it, at least not without coaching. Was this a case of "child abuse"? There is no question. Why then was Susie admitted?
>
> Gerrard, now twelve, and from a francophone part of New Brunswick, began showing a variety of bizarre behaviours early in life. His parents couldn't cope either with each other or Gerrard, and so he was taken in by his grandparents. As Gerrard got to school age he was taken into the local school a number of times. On each occasion, the teacher didn't know what to do with him. To get

attention, Gerrard would exhibit more than a normal amount of bizzare behaviour and then the school would send him home to stay awhile. Once he was assessed and labelled autistic, the school stated that Gerrard would have to stay home since they had no program for him. As the grandparents got older they found it more and more difficult to cope. Finally, they agreed to send him to the WFR, some six hours distant by car. Does Gerrard need a special program? The answer is a resounding yes -- both a special school program and either a therapeutic foster or special group home. Is the WFR an appropriate placement? Not really. While the WFR has a caring staff, they have no good program for autistic children nor does it have a small, highly personalized environment such as needed for Gerrard's condition. Above all, while some staff are francophone, the overall language of communication is English, making it doubly difficult for Gerrard. Should the WFR be faulted for accepting Gerrard? No, since neither the education system nor social services sought to set up appropriate programs close to home.

George, age nine, was expelled from school for throwing a garbage can at his teacher. This followed generally unruly behaviour at school and at home, along with a few suicide threats. His mother is worried about the possibility of a nervous breakdown; and so George was admitted to the WFR, less than one hour drive from his home. Does George need attention? Without question. All his behaviour problems cry out for attention. He seems to have learned to get it by acting out in ways that people respond to. Could interventions at home and in school have made a difference and prevented admission? Very likely. Coaching of the mother and of school teachers on how to give George attention for appropriate behaviour and how to extinguish inappropriate behaviour in all probability would have made a big difference a few years ago. Now more drastic action is required. Is the WFR an appropriate placement? In the absence of anything else, yes. But, a more desirable approach would have been the provision of respite care for the mother along with counselling and development of a special behaviour-shaping program in the school.

The several vignettes illustrate the core of the problem. In each instance, people have given up -- sometimes the parents, sometimes the times "the system". In some instances, a relatively simply intervention could have helped the child and the situation. In other instances, the problems have been allowed to accumulate so that a more complex intervention is required. In most instances, the WFR seems to have been a place of last resort.

B. SUMMARY OF MAJOR CHILDRENS' SERVICES PROBLEMS

What the above vignettes and the previous data provided demonstrate is that:

- **Childrens' needs too often are left unattended until they have accumulated to a point where drastic action is required.** That drastic action, in the above instances, involved removing a child from its family.

- **Services when applied seem to be piecemeal and fragmented.** Service providers and parents interviewed readily agreed that too often co-ordination is absent when dealing with a child and family in need. Childrens' needs are multi-faceted involving family, social, education and treatment dimensions. Each is tackled by a different agency. When its repertoire of skills in trying to improve the condition is exhausted or deemed ineffective, referral is made to another agency. Rarely do agencies seem to work collaboratively on complex problems. The WFR becomes the place of last resort. However, WFR itself has a limited number of capabilities so that if the child is deemed mentally retarded, or too behaviourally disruptive, then the child is excluded from most programs and, in turn, referred on yet again or just retained in custodial care.

- **Little distinction seems to be made between the need for "residential treatment" and "residential placement."** Placement may be required when the child is in danger, or the home situation grossly disturbed or unsatisfactory. In a sizeable portion of cases reviewed, treatment could have been provided in the context of the child's life (such as in a school or special day-program) while living at home or in a substitute home. Only rarely would a stay in a special Behaviour/Training residence be necessary for treatment purposes. In most cases reviewed children were admitted to the WFR because of the inadequacies of community facilities, not because residential treatment would have been the method of choice.

- **Absence of elemental supports.** In a sizeable proportion of instances elemental, low-cost support early on would have reduced the level of problem experienced and minimized the need to remove the child from its home or foster home. Respite care for the foster parent who hasn't had a holiday for four years, home-maker support for the family of a severely handicapped child and training/counselling in effective parenting and behaviour shaping skills could make life much more bearable as well as reduce the extent of childrens' needs to near-normal levels. Likewise, front-line PSS workers and school teachers would benefit from training in how to effectively work with the most common forms of disability and/or behaviour problems.

- **Crisis response rather than program oriented services.** Available resources seem to be applied essentially when a crisis occurs around an individual child. In the absence of any program orientation, the specifics of each child's situation appear overwhelming and lead to a flurry of activity.

  Too often these activities only serve to reinforce existing disturbed behaviour (e.g. the child who runs away to get attention, gets moved from one foster home to another. Each time the child finds something wrong with his/her situation he/she runs away and then is moved yet again, rather than dealing with the need to socialize the child into the good and bad points of any environment.)

The foregoing kinds of problems, and others which might be named, are symptomatic of a service system that has not kept pace with changing societal conditions and expectations, nor with improved professional knowledge and techniques. In simpler times, when home and community were more stable, most communities found a way of handling their "problems" -- perhaps not satisfactorily, but children remained at home. For the rare exception, professional opinion supported the notion that it was appropriate to send the person away. The past thirty years has witnessed a substantial shift in both home and community, as well as in professional knowledge of appropriate treatment forms. With a better educated public it not only is morally appropriate, but politically imperative to ensure treatment and services are provided within easy access to most people. The next section examines the kinds of services that would be desirable.

C. DESIRABLE FUTURE SERVICES FOR CHILDREN WITH SPECIAL NEEDS

To presume that the WFR could and should service the entire province needs to be assessed against what the residents of New Brunswick feel is an appropriate way of serving their children. What is most appropriate -- to remove a child from its family, friends and community for service, or to deal with whatever problems there are in or near home?

What is desirable or possible can be determined from two sources -- the values that people hold, and demonstrations of success from programs of excellence.

1. First Principles

Clarification of the values a people hold is a useful way to determine desirable forms of service. These in turn, may be transformed into a series of first principles. The best expression to date of what New Brunswick wants is found in The Child and Family Services and Family Relations Act of the Department of Social Services (1980). The following principles may be inferred from the Act.

- o The family is the basic unit of society.
- o Children should be served in the context of their family;
- o Services should support not supplant the family;
- o When a family is inappropriate, then the nearest approximation to a family should be sought for the child. (i.e. "they should be provided for as if they were under the care and protection of conscientious parents").
- o Children should be treated in a holistic and total way, rather than in a piece-meal, fragmented way;
- o Services should be easily accessible (all persons ought to have equal access to services).
- o Services should prevent the need for institutional care as well as provide alternatives to it.
- o Services should promote personal growth and development in as normal a manner as possible.
- o Services should be provided in a cost efficient as well as cost-effective manner.

Observations on the Above. Several observations might be made with respect to the foregoing as it applies to services provided by the Department of Social Services.

1. The values as expressed by the Child and Family Services and Family Relations Act are positive and progressive, encouraging treatment of the child in the context of its family and neighbourhood insofar as possible.

2. In the documentation we were able to review, the forward looking values have not been translated into statements of first principle nor consistently converted into mission statements and work plans. Some appropriate beginnings are being made, as in developing the "Permanancy Planning" concept within PSS, and elements of the work plan being developed within the WFR. However, there is as yet no mission statement, or resource development/implementation plan for children with significant disabilities.

3. Consequently, any number of individuals or agencies try to do their best, but notions of what is best varies considerably. Departmental personnel (and others outside) feel there is a lack of consistent vision regarding directions in which services for children with special needs are to be developed.

> Recommendation 1: It is recommended that the Department of Social Services be clearly designated as the lead Department responsible for developing services for children with disabilities, and that the Department adopt a statement of first principles, such as those outlined on page 45 in this Report, and translate such principles into mission statements and work plans whereby services for such children may be well served in their natural environment.

2. Evidence from the Literature as to Desirable Future Services

Since the late 1960's, the value of residential treatment for children and adolescents of all kinds have been increasingly questioned. Indeed, in the mental retardation field the evidence is overwhelming that larger residential facilities invariably lead to as many or more adverse side-effects as there might be gains. For children with emotional or behavioural problems similar conclusions are now being reached (c.f. Barker 1982; Shamsie, 1981). But, it is equally clear that deinstitutionalization in the absence of the building up of community alternatives also is not desirable since there are a variety of children with intensive needs which must be addressed.

Broadly speaking, there are three population groups of particular concern for whom, in New Brunswick, there is continuing request for

service at the WFR those who are multiply handicapped and usually profoundly, mentally retarded; those who are severely mentally retarded and usually exhibit inappropriate behaviour: and, children of normal intelligence but with emotional or behavioural problems.

a. Children with Multiple Handicaps and Profound Mental Retardation.

Children with multiple and profound handicaps in many respects are the most difficult to work with. They usually require reasonable access to medical services, and such expert resources as physiotherapy, speech therapy, etc. as well as the application of sound developmental learning principles. Yet, it has been documented by researchers such as Lou Brown et al (1980) and others that given infant stimulation programs, developmental day programs in early childhood, and intensive programming during the school years many of the disabilities often found amongst these children can be prevented. Many of the physical deformities, for example, are entirely attributable to an absence of gross motor movement (i.e. by allowing these children to lie for hours on end on mats without proper body positioning, etc.). It is evident from experiences in a variety of U.S. states and Canadian provinces such deformities can be prevented and the children satisfactorily housed in the community by giving the parents in-home support, or through special foster care programs and special group homes. Two examples of residential programs for multiply handicapped children of this nature in Canada may be found at Ceci's Homes in Toronto and one of the Elmwood residences in Saskatoon.

The challenge with these children is to promote positive growth in basic life-skills areas. For these, as for other children, active day programs are essential. Developmental centre programs may be established in regular schools or adjacent to schools. As a result of initiating developmental centre programs and associated group homes/ parent support programs in Saskatchewan in 1974, that province has found it possible to avoid admitting any children to institutional settings since 1975.

b. Children with Severe Mental Retardation

Severely mentally retarded children with behaviour problems present another form of challenge. In large measure, the presence of these behaviour problems is a reflection of the absence of appropriate developmentally oriented programming earlier in life. Evidence cited by Brown and others suggests that many of the behaviour problems result from attempts to obtain attention, and the absence of means of constructively using the child's available energy. Important preconditions to either preventing or successfully intervening in these kinds of difficulties include the following:

- o Training for parents/foster parents in constructive in-home programming techniques;

- o By the time children with severe retardation are 3 or 4 years of age, the preparation and implementation of individual program plans by developmental day-care facilities, the parents, consultants in behaviour shaping, and others becomes important.

- o When natural parents find it difficult to cope with behaviour, special training homes may need to be set up where the child is admitted for periods of time before returning to his/her natural home or foster home.

c. Children with Emotional or Behavioural Disorders

Children of more or less average intelligence but exhibiting behaviour problems present another form of challenge. Up until recently, residential treatment has been the most commonly prescribed solution. The traditional rationales may be summarized as follows:

- o It is said to be the most intensive form of treatment -- thus, it can be available 24 hours a day, 7 days a week;

- o It provides a therapeutic living environment, for a therapeutic melieu to any specific treatment that is provided;

- o It separates the child from the family and from the school and neighbourhood social environments so as to allow for assessment of the child's "problem";

- o It tends to legitimize the child's problems as being manifestations of "sickness" rather that just pure "badness", thus relieving guilt on the part of all concerned.

Barker (1982), among others, challenges the foregoing assumptions.

- o He questions whether most if any residential facilities in fact have intensive residential treatment programs, any more so than might be provided in a regular home or a special home (especially since children are asleep for eight hours or more in every twenty-four, they need to relax and engage in free play at times, etc.).

- o The benefits of a special therapeutic living environment is "usually a clumsy, uncertain and expensive way of bringing about change in a family system." Admission is usually inadvisable for children who have no home or a home so grossly disturbed or unsatisfactory as to be quite unsuitable for the child. On the other hand, certain children who have suffered

from serious deprivation of parental care, still untreated by the early teens may require a specialized residential treatment.

- The supposed desirability of separating child from family, school and neighbourhood is questionable if the primary problem is the child's environment. It would make more sense to try to change the environment and to make it more constructive and healthy for the child. In instances where environments cannot be changed, then alternative residential programs seem in order, though that alternative as nearly as possible should approximate a positive home environment.

- Admission as a guilt-relieving mechanism has little evidence available for it, and fundamentally would seem to be poor professional practice.

A desirable array of services for children showing emotional or behavioural problems would include:

- A counselling support group for parents with children of this nature;

- A family and youth service (perhaps provided by church groups, YMCA's Family Service agencies, etc.) providing leisure programs, special day programs in summer, etc.;

- An inter-disciplinary team consisting of a knowledgeable paediatrician, child psychiatrist, psychologist, psychiatric social worker, etc. who can be available to provide helpful guidance and advice to parents, foster parents and other professionals involved;

- A crisis team of individuals available to go into the home as and when required;

- A crisis residence to absorb children when parents or foster parents require respite, and the situation requires decompression (i.e. where it is important to get the child out of a chaotic situation);

- Special foster homes, with professional back-up support, to accommodate children when the natural family finds it impossible to do so;

- A special behaviour training residence for those children requiring longer term, intensive treatment (the province of Saskatchewan has approximately 60 such spaces in group homes of up to 6 children to serve the entire province).

- o Knowledgeable and supportive day programs in schools, etc. so that children can remain involved receiving specialized treatment:

- o The involvement of knowledgeable professionals in regional hospitals, mental health clinics as well as community agencies in joint, holistic treatment approaches.

d. Common Service Requirements for all Hard-To-Serve Children

A common characteristics of all three of the above groups is that they present difficult problems requiring complex solutions. In addition, each individual situation is relatively different from every other one so that single program solutions by themselves usually are insufficient. What is commonly required by all is:

- o an **inter-disciplinary approach** which combines the expertise of psychologists, social workers, physicians, educators, nurses, parents and others;

- o an **individual program planning** (IPP) process in which the various facets of a child's needs are factored out, and through which a common treatment approach is adopted; and,

- o implementation of a **case management** technique through which a case manager ensures that all parties to an IPP carry out their responsibilities in an efficient and effective manner.

Recommendation 2: It is recommended that the Department of Social Services vigorously pursue development of a comprehensive array of services for children with severe/profound handicapping conditions and/or exhibiting emotional/ behavioural problems including child-centred individual programming, case management, and inter-disciplinary team approaches.

VI. CONSTRAINTS, OPPORTUNITIES AND NEW DIRECTIONS

New Brunswick is in a position where it could, if it wishes, in a relatively short period of time develop a high quality services for seriously handicapped or disturbed children which could set a standard for the Atlantic region of Canada. In part, this is so because there is relatively little infra-structure that needs undoing before new programs and directions can be established. In part, it would also seem that there is a growing political "will" to seriously pursue new directions -- an important element to the success of any high quality program.

In this section we examine the constraints currently existing, as well as opportunities. We conclude with a number of major recommendations as to means whereby the opportunities can be turned into reality.

A. THE COMMUNITY SERVICE CONTEXT

In terms of constraint facing both children in need of services in the community, and service providers, the following seems to be the state of affairs.

- Apart from the WFR there are few services available to children who have multiple handicaps, are severely mentally retarded or exhibit behaviour problems. Any one of these conditions may place sufficient pressure on the parent/foster parent, and on the school leading to subsequent admission to the WFR.

- Access to the WFR is a problem directly in proportion to distance as well as to one's ability to function in English.

- Few specialist support people currently exist in the field who readily make their time available to provide guidance or counselling to PSS workers, teachers, parents, etc. on how to

manage in-home behaviour problems, or address the needs of children with mental handicaps.

- o No co-ordinated, inter-disciplinary assessment and diagnostic service is available for parents and workers to access throughout New Brunswick.

- o Apart from the WFR, no staffed crisis relief residences exist to allow for "decompression" of chaotic family situations.

- o There is an absence of co-ordinated approach to children with complex varieties of needs, nor is there any wide-spread experience in developing individualized program/education plans, or in the organization and operation of case management services.

- o There are a few, but still very limited number of specialized resources in the region such as therapeutic foster homes, resource rooms in schools, etc., meaning that a substantial amount of development work is required in these areas to ensure personnel are in place, knowledgeable about how to carry out program plans once they are established.

On the other hand, a number of opportunities exist.

- o Neither the WFR nor community service personnel seem to have used to the extent possible expertise such as the paediatricians and other specialists associated with regional hospitals. Interviews with several representative members of these and other professions suggests that there would be willingness to become involved in a concerted, programatic effort to ensure development of improved services for the children in question.

- o The Department of Social Services already has in place a funding mechanism to provide respite care, homemakers support and other soft-services to natural families and foster families, but these have not been used in any systematic way to date to promote the improvement of community services for severely, multiply handicapped children.

- o Both the Department of Social Services and the Education System have experimented with new innovations such as the seven therapeutic foster homes, two pilot education programs, etc. These need to be expanded upon and elaborated so as to make available a richer array of potential resources in the field.

- o The Department of Education has fostered provision of specialized diagnostic and assessment services through its Comprehensive Plan for Children with Learning Disabilities. These services could be supported and enriched.

- o Special education programs already exist for certain categories of children. These need to be expanded upon to include children now being excluded.

- o The mental health system is currently reviewing its role with respect to many of these children. That system should be encouraged to become more involved in a program-specific way with children having emotional/behavioural problems, rather than the eclectic manner in which such services now seem to operate.

- o The institutions of higher learning such as the community colleges and universities, could become more involved in planning for and training of personnel appropriate to the needs of community services.

- o Parent groups as well as foster parents are expressing an interest in being involved in a collaborative way in planning for and ensuring implementation of high quality services on a community and regional basis.

Recommendation 3: It is recommended tnat the Department of Social Services encourage its PSS personnel to use available, discretionary funding mechanisms to increase the availability throughout New Brunswick of respite care, visiting homemaker service and other similar services to parents/foster parents caring for children with severe problems so as to enable them to more adequately cope with and help children with disabilities presenting demands on the family considerably beyond those normally expected.

Recommendation 4: It is recommended that the Department of Social Services take the lead in initiating a planned approach whereby Social Services, mental health, education, public health, justice, and the many other programs and agencies having an interest in a child can work together in a co-ordinated, holistic and integrated manner.

B. THE WILLIAM F. ROBERTS HOSPITAL SCHOOL

The WFR, for its part, also brings a variety of constraints as well as opportunities to this context. The constraints include the following.

- o At present, it is largely isolated both from community service delivery mechanisms as well as from the available expertise in the community. This is a characteristic of institutions which can only be overcome by devolving such a facility into the community.

- o As a consequence, WFR personnel have little experience in meeting community service needs (such as conducting assessments in home, school, or other community service contexts: providing consultative expertise to community service personnel and parents; helping set up community services such as respite care in the community, crisis residences, etc.).

- o Personnel at the WFR exhibited an uneven level of competence and expertise in their respective disciplines. It was difficult to ascertain whether this was due to staff having become themselves "institutionalized", or they had simply not had appropriate kinds of experiences.

- o Organized programs in general, and individual program plans in particular, were notable by their absence as were a variety of other what should be standard professional procedures.

- o A much improved level of demonstrated competence needs to be acquired in a host of organizational/administrative areas such as developing/implementing a consistent program model and internal service delivery system, improving training and documentation capabilities, etc.

On the other hand, the WFR does represent a significant resource in a number of dimensions.

- o The WFR represents 79% of all special funding resources DSS now spends on these children, and a larger portion of experienced personnel.

- o Many of the personnel exhibited a high level of care for the children with whom they worked.

- o Some of the personnel had a level of expertise that could be readily used in a variety of contexts throughout New Brunswick, whereas the majority of the remainder were capable and seemed willing to learn improved approaches to programming, case-management, assessment and diagnosis, etc.

- o Given appropriate challenges and opportunities, there is reason to believe that a large portion of the 238 personnel at the WFR would gladly pursue development of improved services for children close to the child's home if the opportunity was given.

Recommendation 5: It is recommended that immediate steps be taken to plan for the retraining of program personnel within the WFR to the highest level of competence possible in respect to functional assessment techniques, the use of

assessments in developing individual program plans, the implementation of individualized programs, the co-ordinated use of the inter-disciplinary expertise available etc. So doing would enable personnel both to do a better job within the WFR, as well as prepare them for relocation to community services as valued resource people.

Recommendation 6: It is recommended that the WFR personnel and programs be re-organized so as to allow for more inter-disciplinary collaboration in implementing programs internally and, at the same time, to achieve better interface with community service personnel in the regions (specific proposed changes are outlined in Chapter VII).

Recommendation 7: It is recommended that a three-phase process be followed whereby WFR resources would be reallocated to establish a dynamic, community-based service network for disabled children and families in their own region of New Brunswick.

C. THE NEED TO PLAN FOR CHANGE

The foregoing recommendations imply a substantial change over time both in the community as well as within the WFR. Such change is not likely to occur unless two significant elements are present:

- o Political "will" to ensure that the directions are pursued consistently over a period of at least 18 months to 2 years; and,
- o Participation of staff.

If properly implemented it can be anticipated that, while a certain number of problems will have to be overcome, a change in program direction can be achieved in a relatively quick period of time and with the support of a high portion of the personnel.

Moving from an institution-based service to a community-based service is a complex task which requires a change of current practices and assumptions. It requires a process that involves the various vested interest groups, protects personnel from undue fears regarding job security and related issues; and, at the same time, provides opportunities for personnel wishing to improve their ability to serve children. In turn, this will require leadership from the highest level of government. Chapter VII provides a three-phase plan the Department may follow to achieve the proposed changes.

VII. A THREE-PHASE PLAN TO SHIFT FROM INSTITUTION-FOCUSED TO CHILD-FOCUSED SERVICES

Previous chapters have reviewed the nature and appropriateness of services for children with developmental disabilities or behavioural disorders. As a rule, we find no justification for treating children in residential institutions -- whether on scientific, professional or humanitarian grounds. At the same time, there is every justification for arranging services so as to enable the natural environment better to cope and assist a child with needs and his family.

An examination of existing services indicates that, at present, available special resources are predominantly vested in the WFR and other residential institutions. This chapter outlines a three-phase plan whereby available personnel and fiscal resources might be shifted from its present institution-focus to child-focused community services.

A UNIFYING MISSION

The mark of a successful enterprise, whether in human services or in other sectors, is a clear mission with which all organization components identify and towards which all objectives and implementation plans are directed. The Department of Social Services has established a positive framework through its Child and Family Services and Family Relations Act. This framework needs to be translated into a Mission towards which all services for children with special needs might be oriented. We propose the following:

> PROPOSED MISSION STATEMENT
>
> It is the aim of the Department of Social Services to enable all disabled and/or disturbed children to live productively in their natural environment.

Adoption of the foregoing mission statement implies that all components of the department need to demonstrate how their objectives and work plans help fulfill the mission. The three-phase plan below

provides a broad outline of how community and institution based resources may be refocused so that the intent of the mission might be met.

PHASE ONE

Three objectives need to be accomplished at the outset:

First, to broaden the limited repertoire of responses of both community service and WFR personnel to children presenting extra-ordinary challenges/problems (i.e. to broaden the range of skills staff have as well as to promote more consistent high levels of professional practice);

Second, to develop co-ordinated, client-specific, inter-disciplinary service planning and programming approaches both within the WFR and in the community; and,

Third, to begin linking WFR resources to the community.

A tightly scheduled time-frame should be established for Phase I lasting approximately 3 months from the point after which serious initiatives are undertaken.

Major tasks to be undertaken in Phase I include the following.

A. In Each DSS Region

1. Expected Outcomes. Several outcomes should be anticipated by the end of Phase One. First, all DSS Regions should be preventing admissions to institutional settings of children age 12 and under. Second, there should be a noticeable improvement in quantity and quality of support to natural families and foster families so as to increase their coping capacity. Third, a Regional Project Implementation Committee involving all relevent government departments and agencies should meet regularly both to develop Individual Service Plans for "hard to serve" children, and to develop plans for improved services. Fourth, carefully planned training should be underway for parents, foster parents, agency personnel and others.

2. Implementation Tasks. The following tasks are recommended as being important preparatory steps for services to be provided for all children in their natural home/community environments.

   - o PSS workers should **strengthen natural families and foster families** with children presenting demanding needs by increasing the availability of respite services, homemaker services and related other services, when such services might make the difference between giving the child up or coping.

- o Increase the number of **"therapeutic foster"** homes beyond those now in place so as to provide a first level back-up to natural families finding it impossible to cope. Properly developed, such homes would keep natural families involved with their child to the extent possible. PSS and/or other agency personnel would need to co-ordinate such arrangements, provide on-going support, etc.

- o **Individual Program Plans** (IPPs) should be developed in the first instance for all children with the most severe disabilities and/or behavioural problems in a Region. This requires the involvement of public health, mental health, education/school, justice, medical and community agency personnel.

- o A **Regional Project Implementation Team** (perhaps involving the same individuals who develop IPP's) should begin planning for the return of children currently served by the WFR and other out-of-province institutions. Appropriate WFR personnel should be involved in this process.

- o **Training** should be planned for and introduced as follows:

  - for natural and foster parents, group home personnel, etc. -- parent effectivness skills, behaviour management techniques, etc.;

  - for front-line and mid-level workers in social services, education, health, justice, etc. -- skills relevant to developing and implementing IPPs and individual service plans;

  - for agency heads, program managers, etc. -- orientation to ways in which effective regional inter-agency service networks might be put into place and maintained, service planning, adaptive management techniques, etc.

- o Planning should begin for an **office/resource centre site** out of which a Regional Inter-disciplinary Team would work (see Page 62). Such a centre (to be opened as part of either Phase II or Phase III) might begin in a house but eventually would move to an office site.

B. Within the WFR

1. Expected Outcomes. Phase I outcomes within the WFR should include: First, programming for the children should be more client centred. Second, staff should be re-organized into more effective inter-disciplinary teams. Third, responsibilities for groups of children should be so re-organized as to encourage a continuous linkage

between children in the institution and their community of origin. Fourth, initiatives should be well underway to build increasing numbers of relationships between personnel within the WFR and the community services throughout New Brunswick.

2. Implementation Tasks. The following major categories of tasks are representative of the many initiatives within the WFR that should be encouraged. It may be noted that some have already begun to a modest degree. These need to be focused and enhanced. Others will need to be developed anew.

   o **Create Four Inter-disciplinary Teams** within the WFR. The configuration of children within the WFR, with one exception, should be re-organized so as to promote relationships with their community of origin. Recommended re-organization would be as follows:

     - Francophone Team. All children of francophone background should be the responsibility of a francophone inter-disciplinary team. By housing these children in one place, and placing programming responsibility on a completely francophone team it should be possible to begin approximating an environment more similar to that from which the children come. Apart from being responsible for programming within the WFR, members of the francophone team simultaneously should begin working with personnel in northern New Brunswick to develop appropriate community supports for the children in their responsibility.

     - Saint John-East and Saint John-West. The majority of children should be divided into two heterogeneous groups distinguished chiefly by child's community of origin. Our recommendation would be to divide them into those who might be described as from "Saint John-West" and "Saint John-East". The western group would incorporate the Fredricton and Woodstock regions, while the eastern group would incorporate the Moncton and Newcastle regions. One unit would be headed up by the chief social worker, the other by the chief educator. Otherwise, their personnel would be as described below.

     - The Exception. The exception would be to house together in one unit the children in the infirmary (E1) plus the girls in E2 who are judged to be capable of being released in short order. This unit might be led by the nursing co-ordinator or a well qualified Occupational Therapist. The personnel for this group would be similar to that of other units with the exception that it would have a larger contingent of nursing staff to ensure high quality health care. However, all nurses involved, including the nursing coordinator, should be

challenged to become highly knowledgeable about IPP techniques. The unit should be encouraged to begin immediate discharge plans for the capable children. Thereafter, the unit personnel should concentrate on developing sound programming for the severely involved and profoundly handicapped children. In many respects, these are the most challenging children within the WFR. Personnel trained to work with these children will become invaluable resource people throughout New Brunswick when discharge arrangements for the children are made in subsequent stages.

- **Staff Reallocation.** Staff within the WFR should be reassigned from their current departmental structure to a new interdisciplinary team structure, each with total programming responsibilities for a group of children in their care. Each team would be headed up by one of the existing senior personnel and, in addition, would have as members at least: one psychologist, one social worker, three to four educators, a nurse and a cadre of residential counsellors sufficient to meet the requirements of twenty-four hour, seven day per week programming requirements. Each team would be responsible for developing a complete array of programs for the children in their responsibility. They would immediately begin developing and implementing IPPs for each child. As well, they would prepare for appropriate discharge arrangements in collaboration with PSS and other personnel in the region. **Each child should be assigned to one team member** who's responsibility it would be to ensure the child's IPP development, implementation and eventual movement back to community of origin. **Each team member**, from team leader on, **should be responsible for at least one child.**

- **Set up the first Travelling Assessment/Diagnostic Team.** An assessment/diagnostic team should be established immediately to begin providing travelling assessment and prescriptive diagnostic services in the anglophone part of New Brunswick. The team should include a psychologist, a social worker, an educator with sophistication in psycho-educational techniques, a nurse, and a physician. While such a program might begin on the grounds at the WFR (i.e. the former staff house), **initiatives should immediately be taken to establish a linkage with the Saint John regional hospital.** We would recommend that such a team eventually be based at the hospital so as to take advantage of expertise located there and, conversely, tie regional hospital expertise more directly into regional program planning a service for hard-to-serve children/families. During Phase I, this team would be expected to screen all referrals for admission to the WFR, and to work with regional personnel to determine appropriate alternatives. In addition, they would be expected to develop highly expert assessment and prescript-

ive programming skills to be made available to community service groups throughout the anglophone part of New Brunswick.

- o Introduce Well Planned In-Service Training. To achieve the foregoing, it will be imperative to introduce a well-planned in-service training program immediately. Such training should be designed to improve capability of staff to undertake functional assessments, develop individual program plans, implement such programs, establish linkages with community services, how to work with community agencies in devolving institution based to more child-focused community programs, etc.

PHASE TWO

The objectives for Phase II should be:

First, to strengthen the emerging capabilities of personnel to provide high quality, individualized, client-focused programming and services;

Second, to establish a number of pilot community-based programs for severely disabled and/or behaviourally disturbed children; and,

Third, move the first of the children and staff from the WFR to community-based services contexts.

A. In the DSS Regions

1. Expected Outcomes. Several important outcomes should flow from Phase II. First, plans for a complete array of regionally based services for all special needs children should be finalized. Second, personnel in the regions, the WFR and central office of DSS should be in a position to decide how best to organize future services in the region, including having answers to questions such as: Should regional services be board run or handled under the auspice of the department? How should specialized residential programs be linked to softer services such as training or homemaker services?, etc. Third, preliminary findings should be available on how to make good use of highly professional assessment and diagnostic teams in the regions as well as on how Regional Interdisciplinary Teams best fit into existing service networks. Fourth, by the end of Phase II from forty to fifty personnel from the WFR should be transferred to the regions along with all francophone children and selected anglophone children involved in the pilot programs.

2. Implementation Tasks. The following tasks represent the types of initiatives to be undertaken in this Phase.

- o **Establish both francophone and anglophone Assessment/Diagnostic Teams** in the community. We would recommend that the anglophone Assessment/Diagnostic Team should be attached to the regional hospital in Saint John both to provide on-going credibility and ensure its on-going competence through the availability of expert paediatric and psychiatric resources located there. Similarly, a francophone Assessment/Diagnostic Team, comprised of some of the WFR personnel, should be attached to a francophone regional hospital and, in this Phase, begin its activities throughout Northern New Brunswick.

- o **Two to three Behaviour/Training residences** should be established on a pilot basis. One should be set up in Northern New Brunswick (e.g. Bathurst), and one to two others in locations such as Saint John, Fredericton or Moncton. The purpose of these residences would be to experiment with their value as:

  - a base out of which regional inter-disciplinary teams might provide training and support to parents, fosterparents and schools on how best to work with children with behaviour disorders, etc.; and,

  - a site where a small number of children and/or families could live for short periods of time when special training was required.

  These residences would be staffed by personnel transferred from the WFR.

- o The first full **Regional Inter-disciplinary Team** would be set up in the francophone part of New Brunswick. This team would have a wide range of responsibilities in providing leadership and back-up support to existing and emerging community services.

- o **Training** would continue for families, teachers, front-line and back-up personnel, etc.

B. In the WFR

1. Expected Outcomes. First, by the end of Phase II all program personnel within the WFR should be highly proficient in individual programming techniques, team functioning, etc. Second, the first major reduction in numbers of children and personnel should be effected. Third, as the numbers of children and personnel are reduced, sections of the WFR should be sealed off and/or be renovated for alternative use.

2. Implementation Tasks. The following tasks need to be carried out as a part of Phase II.

- o Throughout Phase II there will be a need to continue refining the understanding and skills of WFR personnel in various aspects of IPP development and implementation. This includes procedures pertinent to daily living routines, day programs and recreation time. In this context, one would expect a clearer role delineation to occur over time as well as better communication between individuals of various disciplines, and a better understanding of what different professionals can bring to an inter-disciplinary approach to children's needs resolution.

- o Sharpen future goal orientation. Throughout Phase II within WFR planning needs to take place to sharpen the staff's understanding of future program goals and the critical role that WFR personnel will play in ensuring a high quality service throughout New Brunswick as they are transferred out.

- o Increased Involvement with Regional Project Implementation Groups. The extent of contact between WFR staff and the regional personnel will increase in this Phase. Agendas will include:

  - developing discharge plans for all remaining children, these to be implemented as part of Phase III; and,

  - preparing service development plans for the region.

- o Refine use of existing facility. During this period of time, plans need to be finalized with respect to future use of the facility as well as how available space will be best used for continuing programming until all children are discharged. So as to ensure that changes in use of physical plant do not demoralize staff, it will be important to close down sections of the WFR as they are vacated, beginning at the extremities of the building. As spaces are closed down for program use, a beginning could be made in making renovations for alternative future use if this is found to be the desirable option.

- o Staff support, counselling, and decision making. A variety of in-WFR activities will be needed to ensure that staff see clear future roles for themselves. All staff, but particularly housekeeping, administrative and clerical staff will need counselling regarding future career oportunities. With respect to program staff, decisions will need to be made on who works best within inter-disciplinary teams, and who works best as in a direct service role (such as in a group home, day programme, etc.).

PHASE THREE

Only **one objective** exists in Phase III; namely, to establish all services for children with developmental disabilities or behaviour disorders within the community.

1. Expected Outcomes. By the end of Phase III the following outcomes might be expected. First, all children and program personnel will have been transferred to a variety of community-based services. Second, Regional Inter-disciplinary Teams will be in place within all seven of the DSS regions. These will be fully integrated into the existing service network. Relationships between these regional programs and the more expert assessment/diagnostic teams working out of regional hospitals in the province (one anglophone, one francophone) will have been clarified and be fully functional. Third, all basic services required for difficult to serve children will be established in the various regions including behaviour/training homes (as required), crisis residences (perhaps through special foster arrangements), supported school programs within regular schools, specialized behaviour training and counselling services in association with mental health clinics, etc. Fourth, increasing emphasis will be given to early interventions so as to prevent deterioration of children or families with difficulties.

2. Implementation Tasks. Since this phase involves the bringing together of WFR resources with those in the seven regions of New Brunswick, no distinction is made between what should happen within the WFR or in the community. In brief, the major tasks would include the following.

   - Establish **Behaviour/Training residences** in the remaining regions and refine their operation in the light of experiences with the first pilot residences.

   - Establish **community residential services and day-programs for the severely/profoundly handicapped children** both in the infirmary within WFR as well as similar children in the community. Services so developed may take a variety of forms. Some families may simply require support in their own homes plus have available developmental day programs within pre-school or school settings. Other children may require specialized foster home arrangements. Yet other children may require group home settings. To complement any one of these residential settings, there needs to be set up appropriate developmental day programs. The inter-disciplinary teams would be heavily involved in these developments.

   - **Inter-disciplinary teams** should be set up in all remaining regions. These teams would be available to develop with front-line staff appropriate individual program plans, would take

responsibility for training front-line personnel, foster care personnel and natural parents. As well, they should set up crisis response capacity to assist natural parents, foster parents or school programs, etc. requiring assistance with specific children.

- o The nature and composition of inter-disciplinary teams would continue to be refined.

- o Group homes, linked to foster homes in a mutual support network might be added and expanded upon.

IMPLEMENTATIVE ISSUES

A number of implementative issues will need to be considered in the course of introducing the foregoing recommended changes. Some of the more obvious ones are commented on below.

1. The Need for Two-Tier Project Implementation Leadership

The implementation plans will require sophisticated leadership at two levels -- first, within the WFR and the various DSS regions, and second, at the provincial level.

In considering how such leadership might best be exercised, several options were considered.

- o A board might be established with the responsibility for both the WFR changes and development of regional services;
- o The Department of Social Services might take the lead in establishing an inter-departmental, inter-agency provincial Project Implementation Committee which, in turn, could foster the Regional Project Implementation Committees;
- o Project Implementation Committees might be established under a new type of Community Health and Social Service Department which is being given some consideration by the government.

The latter option might be appropriate if, in fact, such a new structure were to be established. However, in its absence, the option can hardly be evaluated. Therefore, we recommend the second option; namely, **that the Department of Social Services, as the lead department with respect to the children in question, establish the two-tiered implementation process.**

The Evaluation Team did consider whether or not setting up an independent board to manage the process would be appropriate. However, we ruled against that notion for a number of reasons. First, the changes required should be undertaken with considerable speed. Establishing a board would mean lengthy delays while board members get attuned to the issues. Second, in our experience, the natural forces within boards are such that they are much better at bui'ding and maintaining new programs that they are at devolving institutions and programs. For these reasons, we would not favour such an entity at this time. In contrast, we would be more **favourably disposed to regional boards** established with responsibility for planning regional community-based services and empowered to draw upon and gradually acquire some of the existing WFR personnel resources.

2. WFR Reporting Relationships

A question may be raised as to whether the WFR should continue reporting to the Community Placement Services Division, or should be transferred to the PSS. We have considered this question with some care and have concluded **there would be no particular merit in changing the current reporting relationship.**

Indeed, there are a number of significant disadvantages, given that we are expecting a rapid change over the next twelve to twenty-four months. Changing the administrative reporting relationship within the DSS would simply allow for a new set of confusions to arise as to what the department really expects of the WFR. Furthermore, given the intense efforts of establishing work plans with measurable results that have been undertaken over the last six to eight months, a change of reporting relationship would call into question the validity of the administrative/management concerns that have been raised from time to time. Although trust between the WFR and central office has been strained, in our view this trust cannot be reestablished by simply shifting actors. A workable arrangement seems to have been established in the past few months which, in the long run, is likely to lead to an increased level of trust and a profitable working relationship.

3. Preventing Admissions and Approximating Fully Community-Based Services

Steps should immediately be taken to prevent the admission of children to institutional settings (except for acute care when children should be admitted to hospital). **As a first priority, a freeze should be placed on admissions to all children aged twelve and under.** So doing will have the effect of ensuring that both the assessment/diagnostic teams as well as community planning groups immediately begin planning for difficult-to-serve children in community contexts. The admission freeze can subsequently be expanded to include children aged 13 and older.

At the same time, **it will be important to begin approximating a full range of community-based services** by expanding upon the kinds of soft services the Department already is capable of (viz. support services to parents and foster-parents). If the plan is acted on as outlined, then expenditures in this area should more than be off-set by recoveries in expenditure later in a fiscal year.

4. Creating an Atmosphere of Willingness to Experiment

One measure of a successful organization is its willingness to try new ways of doing things. The book In Search of Excellence notes that the most highly successful businesses do. This finding holds for human services in our experience. The attitude that "it's O.K. to fail because at least you've tried" is one which should be fostered when

promoting change from dependence on one type of service to another. Given the limited experience New Brunswick has to date in enabling most difficult-to-serve children to live in their natural environment, **we would encourage ways and means to be found whereby an adventuresome, experimental attitude can pervade both the WFR and PSS personnel.**

At the same time, **a willingness to experiment underlines the importance of building into the planning and change process, sound information collection systems.** Time-limited, measurable goals and objectives need to be set up at the end of which judgements can be made as to what works and what doesn't.

5. Instilling a Vision of Successful Community Services for Hard-to-Serve Children

An important ingredient to eventual success is for key leadership to have a mental image of the kinds of services in smaller and larger communities which can, in fact, successfully help hard-to-serve children. Repeatedly throughout the course of this study, professionals, usually within the civil service, would make comments such as: "what you are proposing is not possible in New Brunswick"; or "but not for the kind of children we're dealing with"; etc. The facts are that in several provinces and in a number of U.S. states there are individual programs which have demonstrated, for up to 10 years, the possibility of what is proposed in this Report. None of these programs may be said to be without flaw; nevertheless, they merit considerable attention. No better way exists for individuals to gain a vision of what is possible than to visit such programs. **It is highly recommended that a number of key leaders be enabled to visit a carefully selected set of services both to observe what is possible, and to benefit from mistakes which might have been made in implementation.** If possible, such a group should be accompanied by an individual knowledgeable about the programs with sound analytical skills whose task would be to act as an interpreter.

6. Fiscal Implications

The foregoing recommendations have a variety of fiscal implications. It should be noted that we believe it possible to provide a much improved level of service throughout New Brunswick within the existing budget allocations. What is required is a reallocation of these resources from their institution-focus to a more community-based child-focussed service delivery system. Although there is not likely to be a net reduction in the programming costs in so doing, **the province is likely to experience a relative saving into the future because of much lowered capital cost requirements.** For example, it is estimated that one million dollars are required to make some elementary changes within the WFR (i.e. renovating the 21 bed wards in B Wing to 2, 3 and 4 bedroom sleeping arrangements alone would cost an estimated $340,000; installing a fire alarm system to meet new safety

standards would cost over $500,000; bringing the pool area to a useable stage would cost $85,000; etc.). In the not too distant future, it may be anticipated that the roof of the WFR will need to be replaced. Other wings should be renovated to make the space more personal if it is to be used for residential purposes, etc. Given these factors alone, it is not unreasonable to project a capital cost requirement of five million dollars or more within the immediately foreseeable future should the WFR continue to be used as a residential institution.

7. Time-Frame for Change Process

To effect the changes proposed will require that initiatives be taken in relatively quick order. Technically, it would be feasible to develop program plans for all the children within the WFR and obtain community placements within a five to six months time-frame. However, we would not recommend such a rapid process. Proceeding with too much haste leaves little opportunity for personnel both within the regions as well as the WFR to acquire skills appropriate to best working with the children on an on-going basis in the community thereafter. At the same time, allowing too much time to pass lessens momentum -- and change requires that a briskly-paced momentum is maintained.

For this reason, we recommend a 12 to 24 month timeframe with targets set so that Phases I and II are achieved within eight months, and Phase III is begun by the ninth month.

8. Supporting Staff in Time of Change

Changes such as proposed above can either prove traumatic or exhilarating to staff. Since staff at the WFR and in the community are among the most valuable assets the Department has in planning for child-centred services, a number of steps are recommended.

First, it will be important for the Department to clearly ennunciate its mission with respect to severely disabled children and solicit staff assistance in striving towards the mission by setting up implementation procedures which involve all levels of staff.

Second, a clear recognition system should be set up for personnel who demonstrate commitment to achieving objectives consistent with the Mission, creative ingenuity, etc. Such a system of recognition needs to be consistently applied, and would be just as appropriate for families and foster families who manage noteworthy achievements. Recognition might come in a variety of forms. Certificates with community college or university endorsation would be appropriate for individuals successfully completing training. Recognition in a newsletter or paper for particular achievements is a highly recommended way of both boosting morale as well as signalling to others what might be accomplished. A program manager holding a small party to celebrate the reaching of a milestone, or even to indicate the end of a failed

experiment, is a powerful means of both team building and achieving desired results. The use of such rewards requires sophisticated leadership.

Third, it will be important to clearly set out employment options available to staff.

- o To the extent possible, clear career path options should be spelled out for personnel with success being dependent on the extent to which the personel can demonstrate their ability to meet performance requirements of new roles. Counselling should be arranged for all staff to explore their individual career path options.

- o An early retirement option should be considered for personnel who have been with the department for an extensive period of time. A number of implementation models exist which the department will wish to examine.

- o Employment in a community-based service or elsewhere in the public service should be an option for the majority of existing staff. Staff should be given the opportunity to apply for new community-based positions as they are established, and be given support in relocating.

9. Future Use of Physical Plant

Although not properly within the terms of our study, we did give some thought to the question of future uses to which the physical plant might be put. In considering this question, several observations are in order. First, typical of many institutions, the location of the WFR is such that it is not convenient to a variety of resources within the community, nor is it quickly and easily accessible by public transportation. Even by car, it is somewhat difficult to reach since it is located at the end of a road next to a gravel pit and graveyard, in a rather undeveloped area of greater Saint John. Second, it is evident that several millions of dollars will have to be spent on the building in the not too distant future if it is to be used. Capital costs are likely to be highest for residential use. This set of facts presents some problems in considering alternate use of the physical plant.

Option 1 therefore, might simply be to put up the facility and land for public tender with the intent of converting the area into residential and/or industrial purposes. This approach has been used with success in a few jurisdictions.

Option 2 might be to convert the physical plant into office space. Combined with this office space might be space for day programming, the housing of a resource library etc. Such office space

might conceivably be used by DSS western regional personnel as well as a variety of other community service groups, volunteer agencies, etc.

Option 3 would be to turn the plant over to another entity such as Centracare for its use, with the population of elderly psychiatric patients.

Options 1 or 2 would seem to be preferable, and are worthy of detailed examination. Option 3 may be an acceptable alternative for the elderly psychogeriatric population at Centracare if renovations are made to the residential space. Option 3 should be viewed as acceptable only if alternative, less-restrictive forms of care have been ruled out for the population in question.

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ATTACHMENTS

ATTACHMENT 1

FINAL TERMS OF REFERENCE

1. Review the service philosophy of the William F. Roberts Hospital School, and assess the philosophy's relevance to the provision of sound services for "developmentally disordered" children now and in the future;

2. Examine the WFR Hospital School in the light of current trends in and requirements of the larger human service environment in New Brunswick and elsewhere;

3. Review management practices and organizational arrangements and recommend possible improvements;

4. Assess by target groups, length of residency and provide recommendations for reducing the period of stay;

5. Evaluate the key assessment and treatment programs against goals and objectives approved in November 1982;

6. Provide recommendation(s) for ensuring successful discharge plans and community placement -- identify role the Hospital School should play relative to such placements; and,

7. Review costs of service provision and provide 3 year forecast (tentative and not acted on when it became apparent that our recommendations would be to phase the WFR services to a community base).

ATTACHMENT 2

STATISTICAL SUMMARY OF ADMISSIONS TO THE
DR. WILLIAM F. ROBERTS HOSPITAL SCHOOL IN 1982*

	New Admissions	Re-Admissions	TOTALS
1. Sex of Child			
Boys	40	38	88
Girls	15	27	42
TOTAL	65	65	130
2. Language			
English	59	55	114
French	3	5	8
Other (incl. bilingual)	2	2	4
Not Stated	1	3	4
TOTAL	65	65	130
3a. Age Group - Boys			
1-4 years	4	-	4
5-7 years	7	1	8
8-12 years	19	11	30
13-15 years	16	12	28
16-over	2	11	13
Not Stated	2	3	5
TOTAL	50	38	88
3b. Age Group - Girls			
1-4 years	3	3	6
5-7 years	3	5	8
8-12 years	6	7	13
13-15 years	3	5	8
16-over	-	6	6
Not Stated	-	1	1
TOTAL	15	27	42
4. Discharges Within 1982 of Those Admitted			
Boys	24	28	52
Girls	10	17	27
TOTAL	34	45	79
5. Wardship Status			
None	52	46	98
Temp.	11	3	14
Perm.	2	15	17
Other	-	1	1
	65	65	130

* This Data was prepared by the WFR research staff.

ATTACHMENT 2 Continued

STATISTICAL SUMMARY OF ADMISSIONS TO THE
DR. WILLIAM F. ROBERTS HOSPITAL SCHOOL IN 1982*

	New Admissions	Re-Admissions	TOTALS
6. Home Environment			
Natural Parent	56	41	97
Foster Parent	12	13	25
Group Home	1	6	7
Other	-	1	1
TOTAL	69	61	130
7. Referral Source			
Mental Health Clinic	5	4	9
Doctor	3	-	3
Psychol/Psychiatrist	2	-	2
School	7	-	7
Public Health	-	-	-
Social Services	40	22	62
Parents	1	28	29
Courts	1	-	1
Other	2	6	8
Not Stated/Unknown	4	5	9
TOTAL	65	65	130
8. Referral Purpose			
Relief Care (including in emergencies)	8	55	63
Observation, Assess't Treatment	57	10	67
TOTAL	65	65	130
9. Place of Residence According to School District			
5. Caraquét	2	-	2
6. Shippagan	1	1	2
7. Tracadie	1	-	-
10. Chatham	2	-	2
12. Bouctouche	1	-	1
13. Shediac	1	-	1
15/16. Moncton	10	5	15
19. Rothesay	8	8	16
20. Saint John	19	16	35
21-23. Charlotte County	2	4	6
25. Oromocto	1	5	6
26/27. Fredricton	3	1	4
29. Woodstock	1	1	2
30. Perth-Andover	2	-	2
36. Dalhousie	-	1	1
38. Campbellton	1	-	1
40. Rexton	1	-	1
41/42. Bathurst	2	2	4
Not Stated	11	17	28
TOTALS	65	65	130

ATTACHMENT 2 Continued

STATISTICAL SUMMARY OF ADMISSIONS TO THE
DR. WILLIAM F. ROBERTS HOSPITAL SCHOOL IN 1982*

	New Admissions	Re-Admissions	TOTALS
10. Measured Intelligence Level			
Low Average to Superior	33	3	36
Moderate Borderline to Deficit	19	11	30
Severe Retardation	4	25	29
Not Stated (Relief Care)	9	26	35
TOTAL	65	65	130

ATTACHMENT 3

NUMBER AND FREQUENCY OF COMMUNITY RESIDENTIAL BEDS* BY REGION

Region	No., Type 1 of Beds	Ratio of Beds to Child in Care Population 2	Ratio of Beds to 0-14 N.B. Pop'n.3	Ratio of Beds to 0-19 N.B. Pop'n.3
I	12 E.D. 20 MR/MH	1:39 1:23	1:3200 1:1900	1:4500 1:2700
II	18 E.D. 6 MR/MH	1:23 1:69	1:2200 1:6700	1:3200 1:9500
III	12 E.D. 6 MR/MH	1:20 1:40	1:2900 1:5800	1:4100 1:8200
IV	6 E.D. 9 MR/MH	1:22 1:15	1:2300 1:1500	1:3300 1:2200
V	12 E.D. - MR/MH	1:29 --	1:700 --	1:1000 --
VI	5 E.D. - MR/MH	1:24 --	1:4700 --	1:6700 --
VII	- E.D. 4 MR/MY	-- 1:37	-- 1:3600	-- 1:5000

* Excluding regular foster homes

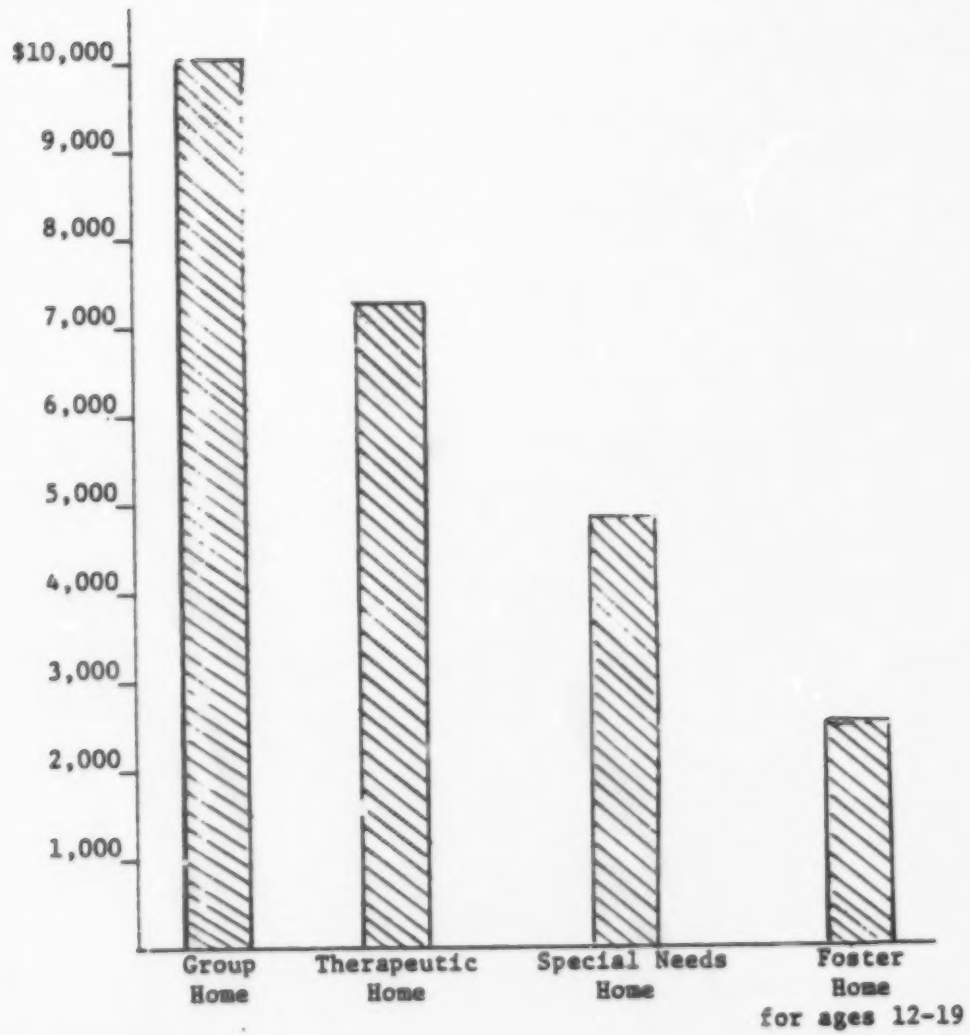
1 E.D. -- children with behavioral/emotional difficulties
MR/MH -- children with mental retardation and/or multiple handicaps

2 Source: Department of Social Services, Child Welfare Statistics Bulletin, September, 1983

3 Source: Statistics Canada Census, 1981

ATTACHMENT 4

AVERAGE ANNUAL COST* PER CHILD FOR
EACH TYPE OF COMMUNITY RESIDENTIAL RESOURCE



* Does not include routine child welfare benefits such as: family allowance; seasonal allowance; health services; special clothing, educational, recreational and cultural expenses

ATTACHMENT 5

OUT-OF-PROVINCE PLACEMENT OF CHILDREN IN CARE, APRIL 1, 1982 - MARCH 31, 1983

Child	Age	Region	Placement	Per Diem	Costs for '82-'83*	Months in Re During '82-'
A	14	2	C.P.R.I., London, Ont.	$189.00	$28,783	5
B	17	4	Bonny Lea Farm, Chester, N.S.	38.00	9,022	6.5
C	16	2	Leader Homes, Queensville, Ont.	49.53	14,299	6.5
D	18	7	Ausable Springs, Brampton, Ont.	51.24	19,176	12
E	16	3	Ausable Springs, Brampton, Ont.	61.04	23,243	12
F	18	2	Bayfield Homes, Consecox, Ont.	63.95	25,927	12
G	17	2	Syl Apps , Oakville, Ont.	191.00	62,500	10.5
H	17	1	Gothic House, Toronto, Ont.	78.53	20,233	9
I	17	1	Bonny Lea Farm, Chester, N.S.	38.00	10,865	8
J	19	3	Ausable Springs, Brampton, Ont.	41.24	17,409	12
K	15	3	Bonny Lea Farm, Chester, N.S.	83.00	7,900	2.5
L	18	4	Bonny Lea Farm, Chester, N.S.	120.00	7,155	2
				TOTAL COSTS	$246,512	

* Costs include per diem, travel, clothing and comforts, medical and dental

ATTACHMENT 6

LENGTH OF PLACEMENT IN AND REASONS FOR DISCHARGE FROM WFR FOR CHILDREN IN OUT-OF-PROVINCE PLACEMENTS DURING '82-'83

Child	No. of Placements	Total Residential Stay (Months)	Reason(s) for Discharge
A	3	42	- unmanageable
B	1	6	- gains made but not reinforced back home
C	1	7	- chronic running - unmanageable
D	4	54	- wardship expired - unmanageable - regression
E	1	24	- did not respond to program
F	1	39	- running - regression - depression and suicidal tendencies
I	3	64	- agression, posed a danger to children and staff
K	1	74	- needed more structured program - regression
L	1	21	- Few gains but not sustained in community

ATTACHMENT 7

IDENTIFIED GAPS IN COMMUNITY SERVICES BY REGION*

Required Services	Region I	II	III	IV	V	VI	VII
Treatment Centre for Seriously Disturbed Children	.	.	.	.		.	.
Mobile Interdisciplinary Teams	.			.	.	.	.
Therapeutic Homes		.		.	.	.	.
Francophone Diagnostic and Assessment Centre				.	.	.	
Special Education Programs	.				.	.	
Secure Care Facility/Capacity		.			.		
Residential Assessment			.				
In-home Assessment		.					
Respite Care for Multi-handicapped Children			.				
Group Home for Multi-handicapped Children			.				
Group Home for 16 - 19 Year Olds					.		
Specialized Day Care						.	

* Gaps identified by regional PSS personnel

ATTACHMENT 8

AUXILIARY CLASSES STATISTICS (Anglophone)

as at June 30, 1983

	Society	Teachers	Attendants	Pupils	Age-Range	Teacher/Pupil Ratio
1.	Bathurst	6	4	43	5-21	1:7.2
2.	Black's Harbour	1	1	7	8-13	1:7
3.	Boiestown #9	1	-	7	6-19	1:6
4.	Burtt's Corner	1	2	10	9-21	1:10
5.	Campbellton #38	2	2	12	8-20	1:6
6.	Campobello #23	1	-	3	10-16	1:3
7.	Centreville	3	4	14	7-17	1:4.7
8.	Chatham	2	2	12	5-15	1:6
9.	Dalhousie #36	2	-	12	10-18	1:6
10.	Fredericton	7&1 adm 1 wkshp	6	59	4-21	1:7.4
11.	Jacquet River #36	1	1	6	9-20	1:6
12.	McAdam # 27	1	1	7	9-16	1:7
13.	Minto	2	2	11	8-20	1:5.5
14.	Moncton	16&1 wkshp	13	111	3-21	1:6.9
15.	Newcastle	4&1 SAB	5	28	4-20	1:7
16.	Oromocto #25	3	3	23	5-20	1:7.7
17.	Perth-Andover #31	1	1	5	5-12	1:5
18.	Plaster Rock #31	1	1	6	8-18	1:6
19.	Rexton #40	1	-	4	8-17	1:4
20.	Rothesay # 19	3	5	21	4-20	1:6.7
21.	Sackville	1	-	4	10-19	1:4
22.	Saint John # 20	18	12&5 bus	135	3-20	1:7.5
23.	Salisbury #16	2	2	11	10-19	1:5.5
24.	Shannon #19	1	1	4	14-21	1:4

AUXILIARY CLASSES STATISTICS (Anglophone)

as at June 30, 1983

(continued)

	Society	Teachers	Attendants	Pupils	Age-Range	Teacher/Pupil Ratio
2 .	St. Stephen	5	4	30	6-21	1:6
2[illegible].	Sussex	2	2	11	7-18	1:5.5
2,.	Woodstock	4	4	30	5-19	1:7.5
	June 1983	96	78&5 bus	625		1:6.7
	Dec. 1982	96	71	615		1:6.6
*	June 1982	90	62	618		1:6.8

Totals include Bathurst

AUXILIARY CLASSES STATISTICS (Francophone)

as at June 30,1983

	Society	Teachers	Attendants	Pupils	Age-Range	Teacher/Pupil Ratio
1.	Adamsville	2	2	12	6-18	1:6
2.	Bouctouche	6	5	34	4-21	1:5.7
3.	Campbellton #37	1	1	6	10-19	1:6
4.	Caraquet #5	3	2	17	4-19	1:5.7
5.	Edmunston	7	6	52	4-21	1:7.4
6.	Grand Falls	4	4	26	4-21	1:6.5
7.	Néguac	1	1	12	6-20	1:12
8.	Petit-Rocher	3	2	21	6-21	1:7
9.	Pointe-Sapin	1	1	5	4-19	1:5
10.	Richiboucto #39	1	1	11	4-20	1:11
11.	Rogersville	2	2	11	6-21	1:5.5
12.	Shediac #13	4	2	25	4-20	1:6.3
13.	Shippagan	2	1	10	5-21	1:5
14.	St. Quentin #1	1	2	6	8-21	1:6
15.	Tracadie	6 & 1 SAB	5	33	3-20	1:5.5
	June 1983	45	37	281		1:6.4
	Dec. 1982	45	37	289		1:6.6
*	June 1982	46	35	303		1:6.6

* Totals include Grand Falls

POOR

QUALITY

ORIGINAL